

**An Approach to Medical Missions:**

**Dr. Neil Macvicar and the Victoria Hospital, Lovedale, South Africa,  
circa 1900-1950**

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I do hereby declare that this thesis was composed by the candidate, Martin J. Lunde,  
that it is my own work,  
and that it has not been submitted for any other degree or professional qualification.

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## Preface

While I have aimed to keep the mistakes and misunderstandings in this thesis to a minimum, my gratitude and thanks are many. And, of course, any errors are mine, and mine alone – they are not the responsibility of any who aided along the way. My knowledge has only grown through the insight of others and the end product has only been accomplished by the help of many along the way. I name below only a selection of the many supporting scholars, friends, and family.

At the University of Edinburgh, Dr Jack Thompson, my primary supervisor, has been a help beyond all imagination. His historical insights, perceptions from personal experience within Africa, and keen wit and critique were always needed and relished. In addition, I thank Professor James Cox, my secondary supervisor, for his acumen on religion within the African setting and his appraisal of my work. Miss Margaret Acton, while at the Centre for the Study of Christianity in the Non-Western World, was a bright light in the vast darkness of my ignorance – both in the Centre's library and archives as well as other elements of the Scottish setting and student life. The absence of her presence, along with the late Liz Leitch, is a gaping hole in the community that cannot be replaced. Dr Elizabeth Köpping, while not directly involved with my studies, played a vital role in encouraging me along the way. Going above and beyond the call of duty in answering naïve questions and providing all the right answers for getting through all the University requirements, Karoline McLean, New College Post-Graduate Secretary, was a saviour, and I am very thankful for her help. For their part, Dr Jessie Patterson, Bronwen Currie, and Chrystal Webster, the computing geniuses of the Divinity School and University, were not simply always helpful, but a joy to go to with all my questions and problems (of a computer nature!). And while I did not get the privilege of seeing him as often as I would have liked, I am deeply indebted to Professor Andrew Walls for his role in inspiring my work in this whole arena of study, his graciousness in answering my questions, and always welcoming me with a combination of humility, kindness, and intellect that is staggering. The librarians at the main University of Edinburgh library as well as those at New College were extremely helpful and I appreciate very much the assistance they provided. I must also mention the late Rev Dr Andrew Ross, who provided numerous stories about African life and whose perspective on 20<sup>th</sup> century history, and mission history in particular, was much appreciated.

In examining my thesis, I am grateful to Professor Brian Stanley (Edinburgh) and Dr John McCracken (Stirling). Their thoroughly learned understandings of history allowed for informed comments, perceptive critiques, and discerning questions that challenged and led to a wonderful discussion.

Amongst the many people in locations throughout Scotland, I am particularly thankful to: Dr and Mrs Robin and Storm Burnett, for their wonderful insight on medical mission life in Africa (having spent many years in both Nigeria as well as South Africa) as well as further contacts and literature; Rev John Macrae, who provided first hand information on Scottish missionary life and motivation in the Nigerian setting; George McArthur, who greatly aided my quest to understand particular Xhosa terms and the general South African background; and, Rev Dr Ken Ross, General Secretary of World Mission for the Church of Scotland, for his very helpful work on my behalf and providing personal contacts to help me along the way.

In South Africa, I especially thank: Dr Alan Kirkaldy, who welcomed me and provided contacts and help far beyond the norm; Cory Library staff of Rhodes University: Shirley Kabwato, Victor Gacula, and Zweli Jackson Vena – all with cheerful attitudes, despite my pestering requests; Stephanie Victor, at the Amathole Museum in King William's Town, who was so very patient, gracious, and helpful with the missionary records.

While I did not have the opportunity to include the material and information that many people helped provide me with, I am nevertheless very grateful for their assistance in this process and hope to make good use of their help in future scholastic work. In Nigeria: Rev. Arlene Onuoha, Princess Alu Ibiam, Professor and Dr Tasie, Rev Dr 'Pastor Ben' Benebo Fubara-Manuel; the whole faculty, administration, and student body of ECWA Theological Seminary, Aba – especially Thompson and Clement; and the staff and leaders at the Presbyterian Church of Nigeria head offices in Calabar. In England: Margaret Wilson and Witgar Hitchcock. I am particularly thankful to Victor and Ada Ezigbo, and indeed the whole Ezigbo family, not only for their friendship and scholarly insight, but for taking care of me during my trips to Nigeria.

I was financially aided and am indebted to The Wellcome Trust (Humanities Self-funded Ph.D. Student Grant) and the University of Edinburgh, School of Divinity, (Research Grants) for support to cover travel expenses related to research. For these contributions, I am very thankful.

**Above everyone else, my deepest thanks go to my parents, Al and Karen Lunde, for your unfailing and continued support, encouragement, and love. I cannot tell you how grateful I am and simply have not the words to thank you as you properly deserve. Thank You, Thank You, Thank You.**

## **Thesis Abstract**

This thesis examines the thought, work, and impact of the Scottish medical missionary, Dr Neil Macvicar, as well other personnel connected to the Victoria Hospital at the Lovedale mission in the Eastern Cape. Of special concern for study in medical history, missiology, and relief development studies, this work centres on Macvicar's modern Western conceptions of Christianity, biomedicine, civilisation, African cosmological understandings, and traditional methods of healing, within the last years of the Cape Colony and the early history of the Union of South Africa.

Macvicar was heavily influenced by the scientific advances and thought of his day, which in turn shaped his perceptions and attitudes not only to African worldviews but to his form and expression of Western Christianity and mission work. His efforts to eradicate and replace 'superstitious' thought and 'inadequate' methods of treatment focussed especially on the training of an African elite, including the first certified black nurses and largely unsuccessful attempts to initiate a scheme for black doctors. In addition, he promoted public health education endeavours; was heavily involved with patient care and treatment; enabled the inception of the South African Health Society; contributed countless articles, pamphlets, reviews, and books – both scholarly and popular; and was a central figure in the formation of the South African Native College (later to become Fort Hare University).

As well as Macvicar, this thesis draws upon and exposes the impact of more marginalised medical personnel, such as Jane Waterston, one of the first female physicians in the modern British scheme, and Govan Koboka, a South African medical dispenser. Their work at Lovedale, among others like them in the late 19<sup>th</sup> century, was the primary approach to Western biomedical treatment offered by the mission, though largely unacknowledged in wider historical studies.

This work also reveals how the hospital operated not simply as a place for healing, or indeed of dying, but as a 'sacred' or religious space in addition to its role as an educational centre for patients, and place for the training of other missionaries. Finally, elements of hospital-based biomedical practices, such as surgery, are examined and the Influenza Pandemic of 1918-1919 is looked at as a case study of mission community response to catastrophic disease.

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## Abbreviations

<i>CE</i>	<i>The Christian Express</i>
CL	Cory Library, Rhodes University
CS	Church of Scotland
FH	Fort Hare University
<i>IRM</i>	<i>International Review of Missions</i>
<i>JMASA</i>	<i>Journal of the Medical Association of South Africa</i>
<i>JRAS</i>	<i>Journal of the Royal African Society</i>
<i>JSAS</i>	<i>Journal of Southern African Studies</i>
<i>JTM</i>	<i>The Journal of Tropical Medicine</i>
<i>LJEW</i>	<i>The Letters of Jane Elizabeth Waterston 1866-1905</i>
LC	Lovedale Collection
<i>LWBCA</i>	<i>Life and Work in British Central Africa</i>
<i>NFM</i>	<i>News of Female Missions in Connection with The Church of Scotland</i>
NLS	National Library of Scotland
RF	The Rockefeller Foundation
<i>SAHSM</i>	<i>The South African Health Society Magazine</i>
<i>SAMJ</i>	<i>South African Medical Journal / S.A. Tydskrif vir Geneeskunde</i>
<i>SAMR</i>	<i>South African Medical Record</i>
SANC	South African Native College
<i>SAO</i>	<i>The South African Outlook</i>
<i>The Record</i>	<i>The Record of Home &amp; Foreign Missions of the United Free Church of Scotland</i>
UFCS	United Free Church of Scotland

## Introduction

### Modern Christian Missions

As the Christian religion has spread and grown throughout the world over the last few centuries, it has been increasingly distinguished with the title of 'Global Christianity' or 'World Christianity'. With roots in the post-Reformation world of Western Christianity, this promotion of the Christian faith to 'foreign lands' has certainly seen results in the numeric growth of those who identify themselves as Christian. Yet, for all the labour which was undertaken in the modern missionary movement in the last few hundred years, it was the 20th century which manifested the greatest changes, including the transfer of the numeric majority of Christians from North America and Europe to Africa, Asia, and South America.<sup>1</sup> Much, though certainly not all, of this has undoubtedly been due to the influence of missionaries, while the actual work of propagation has often been carried out by local people.<sup>2</sup>

In recent years, the Western European and North American missionary movement, from the eighteenth to early twentieth centuries, has gained heightened attention in academic circles. It has been increasingly recognised not simply as a marginal repository of information for broader themes of historical study, but for its central impact on, and role within, such varied subjects as theology, cross-cultural thought, imperial studies, or religious studies. Historians, like Brian Stanley, Andrew Porter, and Norman Etherington, have aptly demonstrated that the

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<sup>1</sup> Andrew F. Walls, 'From Christendom to World Christianity', in *The Cross-Cultural Process in Christian History* (Maryknoll, NY: Orbis Books, 2002), 64.

relationship between missionaries and empire ought not to be constrained to a traditional view that has linked the two so closely that missionaries were but a kind of empowered advance guard of imperial subjugation over local peoples.<sup>3</sup> One also thinks of the work done by Andrew Ross, who helped bring to light the sometimes unconventional assessments of Western Christian presence within central Africa. His research on the Scottish Blantyre mission in Malawi<sup>4</sup> during the late 19<sup>th</sup> century has helped the modern reader to see more clearly an example in David Clement Scott as a missionary both at odds with colonial and church authorities and decidedly pro-African. And Ross's biography of David Livingstone has amended the modern understanding of this missionary-explorer to a more accurate rendering, notably different from earlier accounts which caricatured him in their own likeness, especially in terms of the conceptions of Africans, to Livingstone's detriment.<sup>5</sup> Other important work has been occurring in a range of emphases, bringing new understandings to this important aspect of history, especially in helping to better understand and comprehend the subjects so closely intertwined with the North Atlantic missionary endeavour in non-Western lands.<sup>6</sup>

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<sup>2</sup> See, for example, T. Jack Thompson, *Touching the Heart: Xhosa Missionaries to Malawi, 1876-1888* (Pretoria: University of South Africa Press, 2000).

<sup>3</sup> Brian Stanley, *The Bible and the Flag* (Leicester: Apollos, 1990); Andrew Porter, *Religion versus empire?* (Manchester: Manchester University Press, 2004); Norman Etherington, ed., *Missions and Empire* (Oxford: Oxford University Press, 2005).

<sup>4</sup> Throughout this thesis I typically use the modern terminology for regions or countries, though often including the historical names parenthetically.

<sup>5</sup> Andrew Ross, *Blantyre Mission and the Making of Modern Malawi* (Blantyre, Malawi: Christian Literature Association in Malawi, 1996); *David Livingstone: Mission and Empire* (London: Hambledon & London, 2002).

<sup>6</sup> To name but a few, see, Patrick Harries, *Butterflies & Barbarians: Swiss Missionaries & Systems of Knowledge in South-East Africa* (Athens, OH: Ohio University Press, 2007); John de Gruchy, ed., *The London Missionary Society in Southern Africa, 1799-1999: Historical Essays in Celebration of the Bicentenary of the LMS in Southern Africa* (Athens, OH: Ohio State University Press, 2000); Andrew F. Walls, *The Missionary Movement in Christian History* (Maryknoll, NY: Orbis Books, 1996). See

The modern missionary movement certainly had as its goal a conversion to the Christian religion. To this end, evangelism was of course a central effort, though other aspects of the missionary endeavour were often heavily emphasised. Education and the promotion of literacy, for instance, was a mainstay for many Protestant efforts. The ability to read allowed new Christians the opportunity not only to read the Bible and other religious literature, but was also seen, by many missionaries, as part of the effort to civilise ‘primitive’ or ‘uncivilised’ peoples. Another prominent method and means of missionary work, especially after the middle of the 19<sup>th</sup> century, was the use of medicine and attempts to heal through Western biomedical practices.<sup>7</sup>

## Medical Missions

With the rise of medical missionary work, doctors and nurses (and even non-medically qualified missionaries) became just as integral to many mission stations as clerical, teaching, artisan, or other staff. And as the years progressed through the late 19<sup>th</sup> and early 20<sup>th</sup> centuries, skilled medical workers were not only demanded, for many areas of mission activity, but were also a source of pride for missionary

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also the William B. Eerdmans’ Studies in the History of Christian Missions series, edited by R.E. Frykenberg and Brian Stanley.

<sup>7</sup> Gulnar Francis-Dehqani, ‘Medical Missions and the History of Feminism: Emmeline Stuart of the CMS Persia Mission, 1897- 1934’, Currents in World Christianity/North Atlantic Missiology Project Position Paper Number 103 (Cambridge: 1999), 2.

Also note: I typically use the term ‘biomedicine’ in this thesis for Western medical theory, thought, practice, and treatment, though ‘Western medicine’ is sometimes used interchangeably. Biomedicine refers to the inclusion of associated fields such as chemistry, biology, anatomy, pharmacology, etc., in the understanding of sickness and disease as well as the treatment for ill health and preventive medicine. The use of this terminology is not to downplay the importance or efficacy of non-Western traditional manners, methods, and understandings of disease, ill health causation, or treatment. Rather, it simply allows for greater distinction between these two approaches to health care.

societies and church denominations. Healing the sick and the relief of suffering were not only ethically valued enterprises, but provided physical accompaniment to messages that were sometimes overtly concerned with spiritual matters and the afterlife.



‘Group Waiting in Dispensary’.

Photo of a lantern slide used by a Presbyterian denomination in the United States, probably dating to early/mid-20<sup>th</sup> century. Such slides were used in presentations to promote the missionary work of the denomination and explain the ventures they were involved in. This slide shows a group of patients, mainly women and children, in the city of Santo Domingo, on the Caribbean island of Hispaniola.<sup>8</sup>

By the start of the twentieth century, the beginning period for the mainstay of this thesis, over 100 missionary physicians (both men and women) were serving with major Scottish Presbyterian church missionary societies, comprising over ten percent

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<sup>8</sup> Author’s personal collection.

of the missionary personnel on the field.<sup>9</sup> Yet, Africa itself was slower to receive the influx of the medical presence within mission work, as compared with areas like China or India. Mission hospitals within South Africa, for instance, really only began to be constructed in the early decades of the 20<sup>th</sup> century, with the Victoria Hospital, Lovedale, completed in 1898, one of the very first.<sup>10</sup>



Close up of the slide, 'Group Waiting in Dispensary'.

The accompanying text, used in missionary presentations, read: "Santo Domingo is the most recent country entered by Protestant missions. The work is carried on interdenominationally, the Presbyterians being part of the cooperating group. There are many outstanding needs today. Medical work is one of these and is being met through the hospital work under a trained physician from the states [sic]. He has established a nurses' training class of native girls. Some of these have become his helpers and others have gone for health service into other parts of the island."<sup>11</sup>

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<sup>9</sup> James S. Dennis, *Centennial Survey of Foreign Missions* (Edinburgh: Oliphant, Anderson & Ferrier, 1902), 31-34.

<sup>10</sup> Brian J. Mackenzie and A. Stewart Truswell, *Mission Hospitals in South Africa* (Cape Town: Interdenominational Organising Committee, Medical Missions Exhibition, 1969).

<sup>11</sup> From the author's personal collection.

## Methodology

Just a few decades ago, prominent medical historians commented on the dearth of historical work on issues of health, disease, and medicine within the African context.<sup>12</sup> The same could have been said of scholarly work on medical missions. In recent years there has been a flowering of academic effort, some of which has included the medical work of missions in broader studies,<sup>13</sup> while others have laboured in the very specific context of medical missionary work (though not all of it exclusively focussed on Africa, of course).<sup>14</sup> Christopher Grundmann's work on medical missions, *Sent to Heal!*, is the most comprehensive, with an especially noteworthy resource section, while David Hardiman has recently provided what I believe is probably the finest overarching 'introduction' to the subject.<sup>15</sup> Other leaders in specific geographical fields of historical medical mission study have

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<sup>12</sup> K. David Patterson and Gerald W. Hartwig, 'The Disease Factor: An Introductory Overview', in G.W. Hartwig and K.D. Patterson, eds., *Disease in African History* (Durham, NC: Duke University Press, 1978), 1-3.

<sup>13</sup> A few of these include, Lisa Pruitt, *A Looking-Glass for Ladies* (Macon, GA: Mercer University Press, 2005), 114-143; Harriet Deacon, Howard Phillips, and Elizabeth van Heyningen, eds., *The Cape Doctor in the Nineteenth Century* (Amsterdam: Rodopi, 2004); Alexander Butchart, *The Anatomy of Power* (London: Zed Books, 1998); Megan Vaughan, *Curing Their Ills* (Cambridge: Polity Press, 1991), 55-77.

<sup>14</sup> For example, Charles M. Good, *The Steamer Parish: The Rise and Fall of Missionary Medicine on an African Frontier* (Chicago: The University of Chicago Press, 2004); A.F. Walls, 'The Domestic Importance of the Nineteenth-Century Medical Missionary: "The Heavy Artillery of the Missionary Army"', in *The Missionary Movement in Christian History* (Maryknoll, NY: Orbis Books, 1996), 211-220; Charles M. Good, 'Pioneer Medical Missions in Colonial Africa', *Social Science and Medicine* 32, no. 1 (1991): 1-10; A.C. Ross, 'The Scottish Missionary Doctor', in Derek A. Dow, ed., *The Influence of Scottish Medicine*, (Carnforth, Lancs, UK: Parthenon Publishing Group, 1988), 89-101. See also some of the recent outstanding PhD theses on this subject, specifically related to medical missions within southern Africa: Agnes Rennick, *Church and Medicine: The Role of Medical Missionaries in Malawi 1875-1914* (PhD thesis, University of Stirling, 2003); Welcome Zondi, *Medical Missions and African Demand in Kwazulu-Natal, 1836-1918* (PhD thesis, Magdalene College, University of Cambridge, 2000).

broadened the perspective for the whole field, such as Markku Hokkanen's work on Scottish Presbyterian medical missionary work in Malawi in the late nineteenth and early twentieth centuries.<sup>16</sup> Yet for all of this recent interest and analysis, there is still a great deal of work to be done in this important field.

Medical missionary personalities have certainly been of interest to scholars as well as to the wider public and religiously-minded readers.<sup>17</sup> The most famous individual was probably the renowned pianist and New Testament scholar, Dr Albert Schweitzer, who left his life of early fame in Europe for the central-west African country of Gabon, as a medical missionary. Accounts from his experience and observations in this capacity were recorded in his two well known autobiographical works, *On the Edge of the Primeval Forest*, first published in 1922, and the follow-up, a decade later, *More from the Primeval Forest*. From the Scottish background, particular medical missionaries garnered special attention within their contexts. Most often recognized as a heroic explorer of the Victorian age, David Livingstone was also viewed by many as a pioneering medical missionary, having trained in

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<sup>15</sup> Christoffer H. Grundmann, *Sent to Heal!: Emergence and Development of Medical Missions* (Lanham, MD: University Press of America, 2005); David Hardiman, 'Introduction', in David Hardiman, ed., *Healing Bodies, Saving Souls* (Amsterdam: Rodopi, 2006), 5-57.

<sup>16</sup> Markku Hokkanen, 'Quests for Health and Contests for Meaning: African Church Leaders and Scottish Missionaries in the Early Twentieth Century Presbyterian Church in Northern Malawi', *Journal of Southern African Studies* 33, no. 4 (December 2007): 733-750; *Quests for Health in Colonial Society: Scottish Missionaries and Medical Culture in the Northern Malawi Region, 1875-1930* (PhD thesis, University of Jyväskylä, Finland, 2006); 'Scottish Missionaries and African Healers: Perceptions and Relations in the Livingstonia Mission, 1875-1930', *Journal of Religion in Africa* 34, no. 3 (2004): 320-347.

<sup>17</sup> See, for example, Michael Gelfand, *Livingstone the Doctor: His Life and Travels* (Oxford: Basil Blackwell, 1957); Norman Etherington, 'Missionary Doctors and African Healers in Mid-Victorian South Africa', *South African Historical Journal* 19 (1987): 77-91.



Glasgow as a physician.<sup>18</sup> Another Scotsman, Dr Dugald Christie, who worked in Shenyang (Mukden), China, was seen by many, at least in missionary circles of his day, as a leader in medical missionary training and education.<sup>19</sup>

The work or thought of Dr Neil Macvicar and the Victoria Hospital, Lovedale, have certainly been noted before, if even in passing.<sup>20</sup> The historian of medicine within southern Africa, Michael Gelfand, made much of Macvicar's role in advancing Western biomedicine within South Africa, while also having published some of Macvicar's letters from his time at the Church of Scotland Blantyre mission in Malawi.<sup>21</sup> Yet more than any other writer, it was the personal friend, Lovedale colleague, and fellow Scot, the Rev Robert Shepherd, who has written about Macvicar. In addition to Macvicar's contribution to the wider work of Lovedale,

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<sup>18</sup> John M. MacKenzie, 'David Livingstone and the Worldly After-Life: Imperialism and Nationalism in Africa', in *David Livingstone and the Victorian Encounter with Africa* (London: The National Portrait Gallery Publications, 1996), 203, 210-214.

<sup>19</sup> See his own work and his wife's biography, respectively: Dugald Christie, *Thirty Years in Moukden, 1883-1913* (London: Constable and Co., 1914); Mrs. Christie [Iza Inglis], *Dugald Christie of Manchuria* (London: James Clarke & Company, Limited, n.d. [1932]).

<sup>20</sup> Macvicar has shown up as a peripheral person of interest in a number of studies. For example, Andrew Ross, 'Christian Missions and the Mid-Nineteenth-Century Change in Attitudes to Race: The African Experience', in Andrew Porter, ed., *The Imperial Horizons of British Protestant Missions, 1880-1914* (Grand Rapids, MI: William B Eerdmans, 2003), 86; Markku Hokkanen, 'Christ and the Imperial Games Fields' in South-Central Africa – Sport and the Scottish Missionaries in Malawi, 1880-1914: Utilitarian Compromise', *The International Journal of the History of Sport* 22, no. 4 (July 2005): 753.

<sup>21</sup> Michael Gelfand, *Christian Doctor and Nurse* (Sandton, South Africa: The Aitken Family and Friends, 1984), 71-82; Macvicar, and Gelfand, ed., 'The Letters of Dr. Neil Macvicar of Blantyre', *The Central African Journal of Medicine* 14 (August 1968): 178-181, (October 1968): 232-235, (December): 284-286, 15 (January 1969): 18-20.

Gelfand has been criticised by later writers for his colonial 'History of Achievement' manner. See Butchart, who has drawn three classifications for histories of medicine within South Africa: achievement (linear and optimistic in notions of progression by and through biomedicine), function (preoccupied with the role of disease and elements of medical service and legislation), and repression (Western medicine as a tool of colonialism, capitalism, and overarching imperial suppressions); Butchart, *Anatomy of Power*, 2-5.

which Shepherd wrote extensively on,<sup>22</sup> the fifth principal of Lovedale provided a biography of Macvicar, *A South African Medical Pioneer*. Full of a great deal of information and offering the unique perspective from someone who enjoyed a close personal relationship with the subject, this volume understandably tends toward a very positive portrayal of its subject.<sup>23</sup> While undoubtedly an important contribution, Shepherd's work is nevertheless but an introduction to this important figure in medical missions.

Emanating from a perspective in the history of missions, this thesis produces the most comprehensive examination and analysis of the thought, work, and impact of Dr Neil Macvicar and the Victoria Hospital, Lovedale, South Africa. It started by asking the seemingly simple questions, 'What did medical missionaries actually do?', 'How did they do it?', and 'Why that way?'. These questions then combined and culminated in the broader basis for this thesis: 'What was the approach and method of medical missionary work at Lovedale?'

With Neil Macvicar and the Victoria Hospital, there was an ample amount of archival resource material available. In order to gain a deep and varied understanding, both professionally and personally, of Macvicar and his context I have utilised Scottish Presbyterian Foreign Mission records and Lovedale

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<sup>22</sup> Robert H.W. Shepherd, *Lovedale, South Africa: The Story of a Century* (Lovedale: The Lovedale Press, 1941), 256, 264, 281, 337, 345, 348-360, 371, 376, 497, 518; R.H.W. Shepherd, *Lovedale South Africa: 1824-1955* (Lovedale: The Lovedale Press, 1971), 74, 87, 89-91.

<sup>23</sup> This is not to say that the book is necessarily in the typical mould of most hagiographic/heroic mission biographies, which have been so popular in much Christian literature, even to this day. Robert H.W. Shepherd, *A South African Medical Pioneer: The Life of Neil Macvicar* (Lovedale: The Lovedale Press, n.d. [1952]).

documents<sup>24</sup> as well as personal correspondence and papers.<sup>25</sup> In addition to these archival records, Lovedale was especially unique in its production of the long-running missionary magazine, known during this period as *The Christian Express*, and after 1922 known as *The South African Outlook*. Macvicar was not only a regular contributor to these, but to the *South African Health Society Magazine* as well as various professional medical journals.<sup>26</sup> There were also the more popular writings which Macvicar and others produced, much of which concentrated on public health or social matters. Yet while this thesis is a study framed within the field of the missiological history, I have additionally drawn from resources in the history of medicine, South African studies and history, and religious studies. And just as the history of medical missions is increasingly seen in some circles as proto-modern relief development, it is my hope that this thesis will aid any manner of cross- and inter-disciplinary work – whether medical, imperial, religious, developmental, or cultural.

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<sup>24</sup> The Church of Scotland records, comprising materials from the churches which combined at various points to form the Church of Scotland (i.e. The United Presbyterian Church of Scotland, The Free Church of Scotland, and the United Free Church of Scotland) are held at the National Library of Scotland, in Edinburgh. The University of Edinburgh Library and, more specifically, the Andrew F. Walls Library, a specialist library of the Centre for the Study of Christianity in the Non-Western World, were important locations for resource material.

<sup>25</sup> The Lovedale Collection, a broad assortment of primary source material, especially personal papers and photographs from the mission, is held at the Cory Library, Rhodes University. In addition, the Missionary Collection at the Amathole Museum in King William's Town, was a treasure find, with valuable material for this study. The author is deeply indebted to the kind and helpful personnel at both of these collections.

<sup>26</sup> Macvicar was editor of the English edition of the *South African Health Society Magazine* for over thirty years.

## Thesis Overview

In order to set this thesis in a proper context regarding the approach and method of medical missionary work, I thought it was worthwhile to explore the motives and justifications for the emergence and inclusion of medicine within the mission endeavour in the 19<sup>th</sup> and early 20<sup>th</sup> centuries, with an emphasis on Scottish missions. This period of Western biomedical practice undoubtedly witnessed advances in their understandings of disease causation and treatments for ill health. The Scottish background, steeped in a tradition of medical study and progressive breakthroughs from the 18<sup>th</sup> century,<sup>27</sup> certainly played an important role in the advance of medical missions. The Edinburgh Medical Missionary Society, for instance, became one of the earliest organisations set up for the support of medical mission work and a leader in this field thereafter. With influential directors and a structure which financially supported medical students during their education, while also allowing the future missionaries practical medical experience at an urban clinic for the socio-economically disadvantaged in the Cowgate area, the EMMS helped legitimise the medical role within the wider missionary endeavour.

Many authors have rightly recognised the connection between improved biomedical practice and knowledge and the wider emergence of medical missions in the latter half of the 19<sup>th</sup> century, recognising this as the pre-eminent reason for the endeavour. Additionally, many of the most common biblical examples and commands, found most typically in Jesus, have repeatedly been used for justification of medical practitioners within the missionary effort. However, the reasons for the

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<sup>27</sup> Charles J. Smith and J.G. Collee, *Edinburgh's Contribution to Medical Microbiology* (Glasgow: Wellcome Unit for the History of Medicine, University of Glasgow, 1994), 2-17; Helen M. Dingwall, *A History of Scottish Medicine* (Edinburgh: Edinburgh University Press, 2003).

inclusion and support of medical work within missions are much more nuanced and multi-causal. In chapter one, I provide an extensive examination of the justifications for medical missions used by those during this period. Breaking the motives into a dozen broad headings, this chapter reveals the dynamic and varied spiritual, theological, religious, social, cultural, humanitarian, professional, and medical reasons used in this world-wide endeavour.

From the wider aspect of the rise of medical missions, this thesis, in chapter two, turns to the more specific setting of the Lovedale mission. Located in the Eastern Cape region of South Africa, this Scottish mission (first begun by the Glasgow Missionary Society in 1824) was seen by many within mission circles during the 19<sup>th</sup> century as the finest mission institution in sub-Saharan Africa. Yet for all of its impact upon the education and training of South African pastors, teachers, and leaders, Lovedale did not have a medical presence. The Rev James Stewart, the second Principal of Lovedale, was a physician, and for much of his time at Lovedale he was the only trained medical person on the staff. While he tended to some African patients, his medical effort was very limited. Highlighting the work and impact of Jane Waterston, and other medical personnel, such as Govan Koboka, the second chapter of this thesis provides a new look at this unexplored topic of medical work at Lovedale before the advent of the Victoria Hospital, which was erected in 1898. Waterston and Koboka provide intriguing examples of marginalised medical workers who provided health care to thousands of African patients, while having been, for the most part, ignored by future writers. This chapter then concludes with the drive to build and opening of the Victoria Hospital, due almost

entirely to the work and perseverance of D.A. Hunter, an honorary missionary to Lovedale, and concludes with the hospital's subsequent closure during the Boer War.

With the arrival of Dr Neil Macvicar in 1902 as the superintendent of the re-opened Victoria Hospital, the Lovedale Mission enjoyed decades of steady growth in its ability to care for patients. Under the leadership of Macvicar and the hospital Matron, Miss Mary Balmer, the Victoria Hospital became a leader amongst South Africa's mission hospitals. For these medical missionaries, the hospital and medical work of the mission was far greater than simply the relief of suffering or the treatment of diseases.

Central to shaping Macvicar's approach to medical missions in South Africa was his background in science and adherence to emerging notions of social Christianity. Influenced by scholarly criticisms of some traditional ideas in Christianity and the Bible, and believing that new knowledge ought to be replacing held-over or 'superstitious' views, Macvicar sought to enact changes in both Christian belief as well as African traditional methods and understandings of healing. In an effort to eradicate and replace beliefs which he termed 'superstitious' or 'primitive', Macvicar and Balmer trained and educated an African elite – nurses, medical assistants, teachers, and members of the South African Health Society – convinced that only Africans themselves could wholly impact their countrymen. In addition, Macvicar worked to educate the general public on matters of public health, disease dissemination, hygiene, and nutrition, primarily through various pamphlets and booklets, written in a number of southern African languages.

In chapter four I begin with an overview of the growth and changes of the Victoria Hospital under the superintendency of Macvicar. This brief narrative

history encapsulates the period from 1902-1937, with the aid of photographic material from the period, thereby allowing the reader a chance to visualise some of the transformations during these decades. It is clear from this work that Macvicar and the Hospital board sought to enlarge the capacity of the hospital, demonstrating that medical care at the hospital was the foundation in their approach to medical missions.

From this overarching viewpoint, the fourth chapter turns to consider the Victoria Hospital through varied lenses and capacities. With the central task of healing patients, or at least relieving their suffering, the hospital, in reality, was utilised to demonstrate much more than this. As a location of Western biomedical practices, it was a place to exhibit what the missionaries were convinced were superior methods of health care and healing, compared with African traditional methods of healing. A great number of patients, however, did not leave the hospital 'healed', demonstrating the reality of the limited nature of even the best biomedical care during this time. Amongst other themes, such as pedagogical work, I also analyse the Victoria Hospital as a 'sacred space' and the use of the hospital as a place to not simply care for the body but for the soul as well. That a hospital might operate as a religious site is not new, but the Scottish notions of 'proper', almost church-like conduct and surroundings, are noteworthy.

Biomedical advances in the West during this period bolstered the opinions of many physicians and surgeons in their own abilities to heal. However, in the period prior to antibiotic drug treatments, some aspects of biomedical treatment were but palliative at best. Chapter five examines the very subjects which are, of course, of central importance to any hospital: surgery, disease, and ill health. Yet not only was

Macvicar deeply involved with the day-to-day medical work at the hospital, as doctor and surgeon for many years, he was also a contributor to the wider medical community through regular contributions to medical journals. And, indeed, with his work on tuberculosis he became one of the leaders in South Africa on this subject.

Additionally, I present a new look at the role of the Lovedale community during the 1918 Influenza Pandemic. Providing the most comprehensive examination of the mission's response, this portion of the chapter reveals the reactions – both within Lovedale and Fort Hare – as well as amongst locals in the surrounding district. Though utilising the missionary records for this analysis, much is gleaned regarding the local response to the medical work of the mission. And as I maintain, the missionary reflection upon this crisis resulted in sober conclusions on the efficacy of their mission work up to that point as well as new resolve to act in matters affecting rural black African socio-economic and health conditions.

The final chapter of this thesis considers the role Macvicar played in matters of higher education. From an early point in his time at Lovedale, Macvicar became involved with the drive to establish the South African Native College, which later became Fort Hare University, demonstrating his fervent commitment to higher education for Africans. However, while his labour with the establishment of the SANC was ultimately achieved, the actual College paled in comparison to the plans which had once been envisioned for the school. Furthermore, his work to establish higher education programs and degrees for African men met with varied complications, especially due to the involvement of the Rockefeller Foundation and other interests, such as the Phelps-Stokes Commission, which were involved with matters of African education during the 1920s. Macvicar's early dreams for a strong



and vibrant medical school in a mission setting for African men never came to fruition as he envisioned. Nevertheless, his longstanding work in this arena demonstrates a commitment not simply to his trust in the significance of higher education but to his belief in the ability of Africans, a view which was increasingly at odds with the South African government and segments of the white population in his later years.

# **Chapter 1:**

## **Justification and Reasons for the Medical Missionary Endeavour in the 19<sup>th</sup> and early 20<sup>th</sup> centuries, with particular emphasis upon Scottish Missions**

### Introduction

By the turn of the 20<sup>th</sup> century, medical activity had largely been integrated into most of the major Western church-sponsored and independent foreign mission societies,<sup>28</sup> and the background of this group of workers was certainly wide-ranging - culturally, educationally, and denominationally. This environment, coupled with the fact that missionary physicians and nurses had spread to all continents (save Antarctica) and among myriad ethnic groups, physical conditions, and health climates makes for a truly broad subject matter. Hence, one must be slow to generalise or stereotype – even a matter as simple as what medical missionary work consisted of in daily routines.<sup>29</sup> Nevertheless, this chapter examines not simply the grounds for medical activity mentioned within the diverse missionary discourse itself

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<sup>28</sup> ‘Medical Mission’, *The Lancet* 136 (22 November 1890): 1115.

<sup>29</sup> One could compare, for example, the varying examples of Dr John Hitchcock of Uburu, Nigeria, and Dr Dugald Christie of Moukden, Manchuria, both Scottish medical missionaries working in the early 20<sup>th</sup> century (though Christie had begun his work in the 1880s). Once established, Christie’s work centred on the education of a whole class of Chinese medical practitioners, trained in Western biomedical manners. Largely an isolated figure in Nigeria during the mainstay of his vocation, Hitchcock’s actual medical work contained but a portion of his daily routine, saddled as he was with regular preaching, travel, teaching, district management, record keeping, special medical trips, etc. Alternatively, the day-to-day responsibilities and involvements of Dr Neil Macvicar, the central figure of this thesis, varied widely during the four decades of his vocation as a medical missionary. See, Dugald Christie, *Thirty Years in Moukden, 1883-1913* (London: Constable, 1914); W.P. Livingstone, *Dr. Hitchcock of Uburu* (Edinburgh: Foreign Missions Committee of the United Free Church of Scotland, 1920).

but draws out and analyses the implicit reasoning and surrounding factors in this important aspect of the modern missionary movement.

In an historical examination of this subject, the first issues that must be addressed centre not simply on analysing the answers to the questions of ‘What exactly did they do?’ and ‘How did they do it?’ (which have at times been overlooked or misrepresented in recent work within various scholarly disciplines), but to ask, ‘Why did they do what they did?’ and ‘What reasons did they themselves give to support the work?’. With an emphasis upon Scottish efforts and explanations, while employing material from a wide array of examples, we see that the reasons for, understandings of, and approaches to medical missionary work amongst the spectrum of mission societies and individuals<sup>30</sup> during the 19<sup>th</sup> and early 20<sup>th</sup> centuries was both varied and dynamic. It was shaped not simply by theological justifications on the one hand nor medical advances on the other, but often a combination of these factors, as well as other contemporary cultural influences such as imperialism, social changes, notions of racial stereotyping, and benevolent organisations.

Work by notable scholars in the field has certainly touched upon the subject. Andrew Walls, for instance, has categorized the internal reasons for medical missions into four areas: religious imitation and obedience; philanthropic and humanitarian; utilitarian; and strategic aspects, especially in pioneering work as a

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<sup>30</sup> Due to space constraints, I have largely limited this work to various British and American medical missionary endeavours, with the knowledge that there was a great deal of activity by other Western Protestant, not to mention Roman Catholic, labour in the 19<sup>th</sup> and 20<sup>th</sup> centuries.

‘way in’ to the people.<sup>31</sup> Echoing some of these claims, Christoffer Grundmann has also pointed to the overarching theological reason of sharing God’s love as centrally employed in justifications for some of the work.<sup>32</sup> Additionally, Markku Hokkanen has rightly pointed out that some advocates saw in medical mission work the general ability, “to attack the medico-religious beliefs and practices of other cultures.”<sup>33</sup>

While such work has provided an important underpinning, there is still much to glean in this important subject of study. In this chapter I expand upon and examine more closely many of the reasons for the work and how they approached this aspect of modern Western missions, seeking to give voice to the authors whenever possible, while bringing the varied information into wider analysis on the subject. In seeking to answer these aforementioned questions, much more can be understood, especially in wider scholastic discussions of medical history, historical missiology, relief development, and modern inter-disciplinary global studies.

## Biblical and Christian History

One of the most important mandates for medical missions used by many during this period centred on elements from Biblical, theological, and Christian History sources. Such authoritative sources were continually utilised within the discourse and

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<sup>31</sup> Andrew Walls, ‘The Domestic Importance of the Nineteenth-Century Medical Missionary: “The Heavy Artillery of the Missionary Army”’, in *The Missionary Movement in Christian History* (Maryknoll, NY: Orbis Books, 2002), 212.

<sup>32</sup> Christoffer Grundmann, *Sent to Heal!* (Lanham, Maryland: University Press of America, 2005), 210-226.

reflected upon in a variety of manners, some of which are drawn upon and analysed in this section.

### *Expression of Love*

The medical component of the missionary effort was seen by some to be the fullest expression of Christian mission and God's love. In their opinion, if the central aim of missionary activity was to love others and demonstrate compassion, then in what greater manner could this be done, if not by caring for men and women in the midst of their ill health, and healing their bodies?<sup>34</sup> For one author in South Africa, this was the purest and truest reason for medical mission work:

We must be so permeated with the love of God for man that we must wholeheartedly respond to the needs of man for God's saving or healing and with no ulterior motive.

Medical Missions are not merely philanthropic, or pioneer or evangelical agencies, but a mainstay of healing in the service of Christ out of a God-given compassion such as is in the heart of God.<sup>35</sup>

If perhaps overreaching on patients' assessments of female missionary physicians, Jenny Cumming nevertheless advocated this view of the ultimate manifestation of Christian mission:

This branch of work [medical], which is the newest, has, to some extent at least, been the most blest of all. It is not so difficult to convince a woman, coming out of one of our hospitals, that God loves her, after she has proved for herself the love and patience of the lady doctor, who in her skill and wisdom is to the native little less than a demigod.<sup>36</sup>

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<sup>33</sup> Markku Hokkanen, *Quests for Health in Colonial Society* (Jyväskylä, Finland: University of Jyväskylä, 2006), 94.

<sup>34</sup> Mullen, in *Conference on Missions Held in 1860 at Liverpool* (London: James Nisbet & Co., 1860), 22; J.L. Maxwell, Sr., in *Savages: Sick and Sound* (London: T. French Downie, 1915), 69; K.G. Fraser, 'Pioneer Medical Missionary Work in the Pagan Sudan', *SAO* March 1925, 63.

<sup>35</sup> 'The Healing of Christ', *SAO* April 1929, 80. (This was a contributed piece without ascribed authorship, not an editorial.)

<sup>36</sup> Jenny Elder Cumming, *News of Female Missions* (January 1898): 2. Cumming was writing of her work in India.

And while some certainly viewed medical work as a means to entice potential converts (see below), others were critical of this practice, convinced such reasoning was ethically and theologically mistaken.<sup>37</sup> The Scottish educator and missionary to India, Rev Dugald Mackichan commented, “The medical missionary does not exercise his healing art simply in order to win his way among the tribes. In healing the sick he feels that he is fulfilling a part of his Lord’s commission.”<sup>38</sup> And in an address delivered to the Jerusalem International Missionary Council meeting shortly thereafter, Dr C. Frimodt Möller echoed this viewpoint:

People have thought and spoken of medical missions as a philanthropic agency, a pioneer agency, an evangelistic agency, as a means of reaching certain classes, for instance Moslems, women in zenanas and frontier tribes. It is true that medical missions have been an example of good work, that they have first opened certain lands and have made the work of the evangelist easier, that they have won the friendship of hostile people and tribes and opened the doors of zenana. But medical mission work is not a mere agency; it is an essential part of the Christian message, and the motive for healing the sick is a God-given compassion, such as was in the heart of Christ.<sup>39</sup>

Such theologically-minded rationale for the work viewed the loving motivation of medical work just as important as the outcome of the labour itself.

#### *Example and Command of Jesus*

Above every other example within the vast missionary discourse of the modern age is the nearly ever present model of Jesus for all kinds of justifications

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<sup>37</sup> David Hynd, ‘Medical Missions in relation to Private and State Healing Agencies’, *SAO* September 1938, 36.

<sup>38</sup> D. Mackichan, *The Missionary Ideal in the Scottish Churches* (London: Hodder and Stoughton, n.d. [1927]), 149-150.

<sup>39</sup> C. Frimodt-Möller, ‘Medical Missionary Work’, in *Reports of the Meeting of the International Missionary Council at Jerusalem: Addresses and Other Records*, Volume 8 (London: Oxford University Press, 1928), 169-170.

and illustrations. The same was true for the subject of medical missions.<sup>40</sup> Jesus was seen as the example *par excellence* of a healing missionary,<sup>41</sup> and one that was to be emulated: “The justification of the marriage between healing and preaching is the life of Christ”.<sup>42</sup> In articles and reports from missionary journals, Scriptural examples of Jesus’ healing works were frequently cited (often with accompanying notes that though his healings were miraculous the example was still to be followed – with modern biomedical methods).<sup>43</sup> As one promoter explained, the healing ministry of Jesus demonstrated that He was both good and from God, and that the medical work of missions would demonstrate their goodness and godliness in kind.<sup>44</sup> In addition to the example of Jesus’ service of physical healing, support for medical missions was found in his directives for his followers to go and do likewise.<sup>45</sup>

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<sup>40</sup> Jongeneel has pointed out the preponderance of the varying terms of ‘medical mission(s), medical mission(ary) work, medical evangelism, and medical apostolate’ within the discourse over the last two centuries. I typically utilise the first two. See, Jan A.B. Jongeneel, *Philosophy, Science, and Theology of Mission in the 19<sup>th</sup> and 20<sup>th</sup> centuries*, *Missiological Encyclopaedia: Missionary Theology* Part 2 (Frankfurt am Main: P Lang, 1997), 318.

<sup>41</sup> William Keen, ‘The Service of Missions to Science and Society’, in *Selected Papers and Addresses*. (Philadelphia: G.W. Jacobs & Company, 1923), 56.

<sup>42</sup> J. Rutter Williamson, *The Healing of the Nations* (London: Student Voluntary Missionary Union, 1899), 11.

<sup>43</sup> For example, James Miller, ‘Medical Missions’, in *Lectures on Medical Missions* (Edinburgh: Sutherland and Knox, 1849), 26-28, 72-73; W. Burns Thomson, *Medical Missions. A Prize Essay* (Edinburgh: Johnstone & Hunter, 1854), 5-17; E.S. Munro, ‘Medical Missions’, *News of Female Missions* New Series, no. 7 (July 1898): 54; *World Missionary Conference, 1910: The History and Records of the Conference*, Volume 9 (Edinburgh: Oliphant, Anderson, & Ferrier, 1910), 113; C. Frimodt-Möller, ‘Medical Missions and the Indigenous Churches’, *IRM* 18 (1929): 102-103.

<sup>44</sup> James Robertson, *The Medical Profession The Complement of The Christian Ministry* (Edinburgh: Paton and Ritchie, 1855), 2-5.

<sup>45</sup> A few New Testament citations from the Gospel of Matthew include: 4.23-25, 8.16-17, 9.35, 10.1, and 10.7-8, such as, ‘Preach the Gospel to all’; ‘Whatever you did to the least of these ye did to me’; ‘Heal the sick, raise the dead, cleanse the lepers, cast out devils; freely ye have received, freely give’. James Miller, ‘Medical Missions’, in *Lectures on Medical Missions*, 29; W.O. Ballantine, in *The Medical Arm of the Missionary Service*, ed. Edmund K. Alden (Boston: American Board of Commissioners for Foreign Missions, 1898), 8; Agnes C. Bow, ‘Female Medical Missions’, *News of Female Missions* (November 1899): 84; David Hynd, ‘Medical Missions in Relation to Private and State Healing Agencies’, *SAO* September 1938, 36.

Yet, while the ‘Great Physician’ (as Jesus was sometimes referred to within these discourses<sup>46</sup>) was the chief example, the New Testament apostles were also quite often utilized as the human exemplar for missionary healing.<sup>47</sup> Within this pattern were a number of nuanced uses of the disciples. Some commentators, when citing these figures from early Christianity, explained that the methods which had been utilized – miraculous healing – were no longer available to Christians,<sup>48</sup> but that the work of healing, through modern biomedical practices, was the natural means of contemporary medical mission work and in line with the earlier methods. James Miller, then Surgeon in Ordinary, for Scotland, to Her Majesty the Queen, and Professor of Surgery at the University of Edinburgh, relied heavily on the example of the early apostles in a lecture on medical missions:

...The practice of the apostolic Church points so plainly to the appropriateness of uniting the healing of disease with the preaching of the Gospel, as a means of spreading abroad the latter.... True, the circumstances of the present day and of that epoch are not exactly the same. The power of miracles has been withdrawn; but the wisdom and experience of ages have been given instead; and, under many circumstances, even now the power of healing is very wonderful.<sup>49</sup>

It is certainly not surprising that the examples and directives of the early disciples, as well as other biblical characters, were exploited by proponents during the 19<sup>th</sup> and early 20<sup>th</sup> centuries. After all, the evangelical zeal of the various mission societies

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<sup>46</sup> In insightful concluding comments to his lecture on the subject, one source also utilised opposing roles of Jesus: the ‘Great Patient’ and the ‘Mighty Sufferer’. See, George Wilson, ‘The Sacredness of Medicine as a Profession’, in *Lectures in Medical Missions*, 265.

<sup>47</sup> William Swan, ‘The Importance of Medical Missions’, in *Lectures on Medical Missions*, 90; Wilson, ‘The Sacredness of Medicine as a Profession’, in *Ibid.*, 226; Mary and Margaret Leitch, *Seven Years in Ceylon: Stories of Mission Life* (New York: American Tract Society, 1890), 156-157;

<sup>48</sup> There is room for work on the relationship between issues of Christian traditions which incorporate miraculous healing (whether, for example, AIC or Western Pentecostal) and medical missionary work, however, due to space constraints, this important topic has been set aside from this thesis.

<sup>49</sup> Miller, ‘Medical Missions’, in *Lectures on Medical Missions*, 30.



and individuals rested heavily on biblical mandates and cases, especially from the New Testament.

#### *Christian Tradition*

In addition to patterns and instructions from Scripture, another important theological source employed to promote medical missions was found in the realm of Christian History.<sup>50</sup> In this way, illustrations from, as well as understandings of, history were utilized as a witness to support then contemporary exploits and expansionary plans. In the words of one writer on Christian mission work in Africa, “Christian charity towards the sick has ever been a great means of drawing hearts to the Church, since the days when our Lord ‘laid His hands upon a few sick folk and healed them.’”<sup>51</sup> The World Missionary Conference, held in Edinburgh in 1910, included an affiliated Medical Missionary Sectional Conference, whose one hundred and thirty members unanimously passed a statement which called for the recognition of medical missions as an absolutely vital part of the missionary cause, in part, “Because the efficacy and necessity of such work as an evangelistic agency have been proved in many lands again and again, and such work has been sealed by the blessing of God.”<sup>52</sup>

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<sup>50</sup> Indeed, even Scottish Christian history was cited, as in the case of St Ninian. Ibid., 77-78.

‘Medical Missions’, *The Lancet* 171 (6 June 1908): 1640.

In a related subject, John Coldstream, sought to bolster the cause of medical missions maintaining a close relationship had existed between the propagation of Christianity and the practice of medicine in Christian history. Coldstream, ‘On the Responsibilities Attaching to the Profession of Medicine’, in *Lectures on Medical Missions*, 290-320.

<sup>51</sup> A.E.M. Anderson-Morshead, *The History of the Universities’ Mission to Central Africa, 1859-1898* (London: Office of the Universities’ Mission to Central Africa, 1899), 286.

<sup>52</sup> *World Missionary Conference, 1910*, Volume 9, 113.

## Spiritual/Theological

While biblical examples and directives as well as precedence within the history of Christianity were widely utilized, it is necessary to draw attention to another theologically based rationale used for propagating the medical missionary undertaking. These spiritual motives for medical missions were vitally important for many within the practice, as well as those back home who supported their efforts.

### *Distinctively Christian*

If Biblical and Christian historical instances and commands were utilized for sending out medical missionaries, there were other justifications for the endeavour of a more theologically reasoned nature. One of these had its foundation in the idea that there was something fundamentally different in the way in which, for example, a mission hospital might run and how a government hospital operated. For many who were active in supporting and working in Christian missions, there was the belief that God worked in special ways within mission establishments. Such authors maintained that there was less de-humanization and greater care given by loving doctors and nurses in missionary institutions than in government-run centres. Writing at the end of the period this thesis encompasses, J.W.C. Dougall captured the theologically based sentiment of what some believed set missionary medicine apart from secular work of the same nature:<sup>53</sup>

‘Caring is the greatest thing’, wrote Von Hügel, ‘caring matters most. Christ has taught us to care.’ These words might be written above the door of the mission hospital. It is this personal quality in the relationship between doctor or nurse and

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<sup>53</sup> This is sometimes currently reflected, in today’s terminology, as a difference some see in relief development between NGOs (Non-Governmental Organisations) and FBOs (Faith Based Organisations), let alone governmental roles.

patient that distinguishes the Christian hospital. This and the spirit of prayer make medicine a ministry of healing.... Nothing can take their place – no equipment, however modern, no system of administration, however efficient. When the medical mission loses this quality we need not regret that its work should be taken over by other agencies.

.... The Christian medical ministry is based on a deeper diagnosis of human need than any secular interpretation of man's nature can support. As man does not live by bread alone, so human pain and disease need more than physical relief and medical remedy.<sup>54</sup>

Such reasoning was especially apt in periods of growing governmental involvement in medical needs in the 20<sup>th</sup> century, sometimes taking over missionary medical work or openly antagonistic toward mission efforts.<sup>55</sup>

#### *Understandings of Time*

Within another motivation for medical mission work, the argument was laid out from a perspective which viewed larger issues – such as advances in biomedical understandings of disease and increased access to new lands – as under the direct providential work of God. There were further motivations in pursuing the work more immediately because some felt that God might be bringing the particular opportunity for medical expertise at that particular moment, while others thought that the world might be coming to an end. From Edinburgh, in the middle of the 19<sup>th</sup> century, come the words of the eminent surgeon, James Miller:

Is there any special call for Missionary exertion now – alike on the part of the Christian Churches, and of Christian men? Assuredly there is. Now, when common gratitude for blessings bestowed calls to diligent and increasing faithfulness; - now, when, in God's providence, the overthrow of kingdoms and the heavings of the nations plainly tend to a freer and a fuller spread of Gospel light and liberty; - now,

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<sup>54</sup> J.W.C. Dougall, *The Reason for Medical Missions*, reprint (London: International Review of Missions, 1946), 4-5.

<sup>55</sup> M. Scheel, 'Medical Missions', in *Concise Dictionary of the Christian World Mission*, ed. by Stephen Neill, etc. (London: Lutterworth Press, 1971), 377; Evvy Campbell, 'Medical Mission Work', in *Evangelical Dictionary of World Missions*, ed. by A. Scott Moreau (Grand Rapids: Baker Books, 2000), 612.

when a door seems opened whereby we may enter in, and we know not how soon it may be shut, - all the sooner if the opportunity be not seized and improved.... Now, when His providence, by portentous signs, seems [to be] warning men that the end draweth near- that the span of time which yet remains for labour is fast closing in, and that now if ever our work must be done.<sup>56</sup>

Miller's injunction stems from a theology which not only believed in God's particular activity on earth, but in special timing for certain endeavours.<sup>57</sup> While addresses such as this do not necessarily express novel understandings of the justification, method, or approach given for medical mission work during this time, it certainly displays an intense motivation from this early period of modern medical missions – an important reason in helping to understand why such activity not simply took place, but why it was so fervently supported within particular circles.

#### *Uniquely Spiritual Aspect*

In this realm of theologically based reasons for the medical missionary endeavour, one last justification is worth noting. Fletcher Moorshead, writing during the First World War, maintained that participation in the specifically *medical* aspect of mission work was of unique spiritual importance for the whole of both the 'sending church' as well as the "church on the mission field".<sup>58</sup> In Moorshead's theological perspective, there was a special interaction with God which took place when such work was undertaken. While evangelism and other parts of the endeavour

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<sup>56</sup> Miller, 'Medical Missions', in *Lectures on Medical Missions*, 15-16. In just the few following pages, Miller went on to begin eleven sentences with the word, 'now', expressing the exceptional nature of that particular time period; see pp 17-19.

<sup>57</sup> Perhaps Miller had in mind the use of a Greek New Testament word for time, *καίρος* [kairos], depicting a kind of chosen and special time for a certain event or happening, as ordained by God, as opposed to the more typical chronological measuring/understanding of time, stemming from the word, *χρόνος* [chronos]. This may help to understand his particular repetitive use of the word, 'now' within this passage.

<sup>58</sup> R. Fletcher Moorshead, 'The Church in the Mission Field and Medical Missions', *IRM* 5 (1916): 281.

were imperative, it was the medical work which helped people with their dearest physical needs, a special task in Moorshead's opinion:

The ministry of succour for the suffering may prove costly in its output of sacrificial effort, but it never fails to enrich those who engage in it. The pathway of the Good Samaritan may involve the undertaking of many fresh responsibilities, but in the very fellowship with our Lord that it brings it confers a grace and benediction which none who have had the experience would ever miss again.<sup>59</sup>

In the same manner, he believed that the indigenous church's involvement in such work supported their communal spirituality.<sup>60</sup>

## Religious

### *Propagation of True Christian Religion*

If there were those who saw the medical work as the fullest embodiment of the Christian mission to love others, and some on the other side of the spectrum viewed the medical work as purely auxiliary to the central task of evangelism and conversion, there was probably the most popular view which reasoned that the medical mission work was a central part of propagating the Christian religion.<sup>61</sup> In the words of one Glasgow Medical Missionary Society superintendent, "... for truly as the establishment of the kingdom of God on earth is just to promote happiness, diminish misery, and to bring the whole race of man to one common brotherhood as sons of God, so this is pre-eminently the purpose and end of medical missionaries

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<sup>59</sup> Ibid., 281-282.

<sup>60</sup> Ibid.

<sup>61</sup> Watson, 'The Duties of a Medical Missionary', in *Lectures on Medical Missions*, 199-201; Herbert Lankester, 'Letter to the Editor', *The Lancet* 144 (28 July 1894): 226; 'Medical Missions', *CE* August 1898, 127; "A Medical Missionary", *The Medical Mission of the Church* (London: Church Missionary Society, n.d. [1943?]), 9-10, 13-14.

and medical missions.”<sup>62</sup> In reading the missionary discourse through the course of these many decades, the implicit demonstration is clear, through the examples of bodies being healed and lives saved through medical missionary treatment: that they believed their work was enhancing the kingdom of God.<sup>63</sup>

#### *Opening for Religious Work*

For some, medical work was undoubtedly seen as an auxiliary aspect of the missionary endeavour.<sup>64</sup> It was appreciated as a useful tool, especially in areas where Western missions were new, in meeting the local population while simultaneously hoping to demonstrate goodwill.<sup>65</sup> In these pioneering situations, Western medicine and surgery were viewed by some as a ‘way in’ for the ‘real’ purpose of missions,<sup>66</sup> which centred on aspects of evangelism and conversion (with

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<sup>62</sup> Lyell, ‘Superintendent’s Report’, *The Fifth Annual Report of the Glasgow Medical Missionary Society, 1872* (n.p., n.d.), 9.

<sup>63</sup> See, for example, ‘Establishment of Hospitals in China’, in *Statements Respecting Hospitals in China, Preceded by A Letter to John Abercrombie, M.D., V.P.R.S.E., by Rev. Peter Parker, M.D.*, 23-27; *Fourth Annual Report of the Edinburgh Medical Missionary Society* (Edinburgh: Andrew Jack, 1846), 27-28; *The First Annual Report of the Samoan Medical Mission, in Connection with the London Missionary Society, Under the care of George A. Turner, M.B., C.M.: For the Year 1868-9*. (Samoa: Printed at the London Missionary Society’s Press / Reprinted at Glasgow, 1870), 9-11.

<sup>64</sup> Even for those who saw a distinct purpose in medical mission work as pioneering for the wider missionary endeavour, those like Lowe still advocated for the medical missionary to have full missionary status while on the field, not a secondary or lesser standing (not clerically ordained, but as an evangelist). John Lowe, *Medical Missions* (New York: Fleming H. Revell, 1895), 34-37.

<sup>65</sup> Herbert Lankester, ‘Letter to the Editor’, *The Lancet* 144 (28 July 1894): 226; William Muir, ‘Introduction’, in Lowe, *Medical Missions*, v.

Note Muir’s implicit dissenting tone of what he believes is an over-emphasis on medical work in missions as laid out by Lowe: “Some, indeed, may be inclined to question whether medical work may not have been too strongly insisted upon here, as a *necessary* branch of all Missionary and Evangelistic agencies...” [emphasis his].

<sup>66</sup> Some vehemently objected such a motive for medical mission work. See, for example, the harsh words of Frimodt-Möller, ‘Medical Missions and the Indigenous Churches’: 104.

This objection, often from outside the Christian fold, was nothing new. See the response of the then young Thomson: *Medical Missions*, 30-32.

church involvement and other ‘necessary’ changes).<sup>67</sup> John Lowe, long involved with the Edinburgh Medical Missionary Society, wrote, “As a means of overcoming prejudice, and of gaining access to heathen, and often exclusive, communities, medical missions present strong claims to the sympathy and support of the friends of missions.”<sup>68</sup> In a similar way, William Keen observed, “The medical missionary often finds that his professional services open the door to his Christian teaching.”<sup>69</sup> For these advocates of the work, medical care was considered one of the most visibly beneficent acts that could be performed.

It was a faith in the efficacy and results of Western biomedical treatment which they thought would help attract potential converts to them. Writing from Ranaghat, India, Miss E.S. Munro, a female medical missionary, believed there was great value in her line of work for the overarching religious goal of missions:

From what I myself have seen after some years’ work in a Medical Mission, I have no hesitation in saying that as a means of breaking down prejudice, and gaining the confidence of the people, of collecting vast crowds to hear the Gospel message, and opening their hearts to receive it, medical missionary work is the best of all.”<sup>70</sup>

### *Save Body and Soul*

In practice, the religious and medical aspects of work were very often closely intertwined. For some, it was a particularly special situation in which medical

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<sup>67</sup> O’Meara, in *Conference on Missions Held in 1860 at Liverpool*, 245; John Lowe, *Medical Missions*, 51-87; David Hynd, ‘Medical Missions in relation to Private and State Healing Agencies’, *SAO* 20 September 1938, 36.

<sup>68</sup> Lowe, *Medical Missions*, 53.

<sup>69</sup> Keen, ‘The Service of Missions to Science and Society’, 56-57.

<sup>70</sup> E.S. Munro, ‘Medical Missions’, *News of Female Missions*, new series, no. 7 (July 1898): 54.

missionaries were placed – unique for healer and patient. George Wilson, a medical doctor and Lecturer in Chemistry at Edinburgh University, maintained that the missionary medic held an exclusive place, as opposed to clerical missionaries, in their ability to access people in physically distressed states, and therein share the Christian faith.<sup>71</sup> He further clarified his contention for the sacred nature of the medical missionary practice, claiming that it was the exceptional state of people in ill health (especially with life-threatening conditions) which made them especially receptive to discussion of a religious nature and whom missionary doctors and nurses alone would be able to minister to.<sup>72</sup> Dr William Gauld, a medical missionary to Swatow, China, clearly articulated his thoughts on the central aim of the work in a paper read at a missionary conference in Shanghai in 1877. While extolling the goodness of the medical mission endeavour in furthering science, or as a purely benevolent exercise, these were nevertheless secondary motivations.

But there is still a further and greater good to be attained, and, in the attaining of it, all the other advantages will accrue as a matter of course. I mean the saving of their souls. We need to realise the importance of this, as the highest good that can be conferred on our patients. Nothing short of this should, I conceive, be the aim of the medical missionary. Only by keeping it in view will he do justice to his noble calling, and truly follow the example of the Great Physician of body and soul.<sup>73</sup>

And at the Church of Scotland mission (primarily amongst Jews) in Smyrna (modern day Izmir, Turkey), for example, religious services were held within the hospital, after the patients had signed in for medical treatment, but prior to the appointments themselves. Following the sermon, which was typically, “bearing upon some topic on the relation of the Jew to his Messiah and Saviour”, tracts and

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<sup>71</sup> George Wilson, ‘The Sacredness of Medicine as a Profession’, in *Lectures on Medical Missions*, 247-248, 252, 258.

<sup>72</sup> *Ibid.*, 248-249. See also, Miller, ‘Medical Missions’, in *Lectures on Medical Missions*, 22-23.

<sup>73</sup> William Gauld, ‘Medical Missions’, quoted in *CE* January 1878, 6.



New Testaments were also handed out.<sup>74</sup> The medical portion of such missionary work was promoted as an integral part to the evangelistic aspects of the enterprise.<sup>75</sup>

#### *Upending Traditional Religion*

Another rationale for the operation of missionary medicine was to upend traditional religions by demonstrating the superiority of (Christian/Western) medicine and hence the Christian religion which these medical practitioners were also propagators of.<sup>76</sup> Backers maintained that because there was often such a close correlation between religion and medicine in Non-Western cultures – embodied by priestly healers – the most functional response was with Christian medical missionaries. In a response too far reaching in its comprehension of non-Western methods and understandings of healing and wellness,<sup>77</sup> W. Burns Thomson nevertheless exhibits an important justification for the medical mission cause:

In almost every heathen land the practice of physic is conducted by the priest; and a more contemptible empiricism than they follow can scarcely be conceived... Were Medical Missions to do nothing more than relieve our suffering fellow-creatures from the treatment they receive at the hands of the priest, and bestow upon them the benefit of European practice, they would on these grounds alone engage the serious consideration of philanthropic men. But the medical missionary would accomplish much more than that. The priests have so interwoven their medicine with their theology, and so mixed up their practice with their superstitions, that whatever tells against them as physicians, tends to sink them in the estimation of the public as

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<sup>74</sup> R. Lee Bolton, 'Smyrna', *The Church of Scotland Home and Foreign Mission Record* no. 424, new series no. 151 (July 1897): 224.

<sup>75</sup> Mrs. Dickson, 'Notes from Poona', *News of Female Mission* new series, no. 14 (February 1899): 13.

<sup>76</sup> While some historians have maintained that the missionary antipathy toward African traditional healers was due to competing interests in social status, this may mitigate the more pervasive concern of the missionaries, which centred on the religious background and teaching (and which they believed was false). Paul S. Landau, 'Explaining Surgical Evangelism in Colonial Southern Africa: Teeth, Pain and Faith', in *Journal of African History* 37 (1996): 277.

<sup>77</sup> Similar examples of the ignorance of medical mission advocates about non-Western methods of healing were not uncommon. See, for example, Williamson, *The Healing of the Nations*, 13-14.

religious instructors and guides; so that the daily cures performed by the skill of the missionary tends to crush and annihilate the whole system of superstition.<sup>78</sup>

For those like Thomson, there was hardly a better way to upend the traditional religions, interwoven with aspects of healing as some certainly were, than through the vehicle of the medical missionary.

#### *Christian Competition*

If one purpose of the Protestant medical missionary endeavour was to topple many of the foreign methods of traditional healing and religious manners and thought, another justification, of a similar kind, remained. Protestant and Roman Catholic missionary work was sometimes just as heated as other elements of rivalry between these two Christian traditions. At one point in a lecture on the wider subject, William Swan noted with admiration (if not also with reluctance) the successful role of medicine in Jesuit mission history.<sup>79</sup> However, he went on to urgently advocate the use of medical missions to match, if not overtake, the competing work and presence of Catholic missionary activity (which he believed heretical):

Our strife with the emissaries of Rome at home or abroad is a strife with the enemies of Christ's pure gospel... Popish zeal ought to provoke Protestant jealousy. If we cannot see our duty in the light of revelation, and do it under the impulse of motives presented to our view there, we must be shamed into the performance of it by the activity of the votaries of error.... The weapons of our warfare [missionary medicine] are mighty, but *we must wield them*.<sup>80</sup>

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<sup>78</sup> Thomson, *Medical Missions. A Prize Essay*, 28-29.

<sup>79</sup> Swan, 'The Importance of Medical Missions', in *Lectures on Medical Missions*, 101-102.

<sup>80</sup> *Ibid.*, 111-112, (emphasis in text).

It might also be noted that while contention certainly existed between Protestant mission societies at certain times and places, many viewed it as a healthy competition amongst friends and allies in a common cause.<sup>81</sup>

#### *The Non-Western Church*

Within this section another purpose for medical missions must be mentioned, which dealt with a related religious motivation, the ‘Indigenous Church’. Frimodt-Möller, writing between the two World Wars, identified what he believed ought to have been the central factor in promoting medical missions: “... The chief object of medical missions is now to bring into the indigenous Churches the ministry of healing as a part of their work.”<sup>82</sup> Such a view may have been naïve as to the important role of healers which many native Christians had been playing (both with regard to traditional methods of healing as well as Western biomedicine). Nevertheless, Frimodt-Möller’s view contains an important point: the altogether common belief amongst Westerners held that their styles and emphases in theology, ecclesiology, or methods of service, could be – and ought to have been – directly replicated amongst the ‘daughter’ churches.

#### Cultural

##### *Introducing ‘Culturally Superior’ Aspects*

Terms such as ‘ignorance’, and the perception that most non-Western peoples held to ‘superstitious’ ideas, especially in the realm of disease contraction and

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<sup>81</sup> James Miller, ‘Medical Missions’, in *Lectures on Medical Missions*, 19-20; Swan, ‘Importance of Medical Missions’ Ibid., 111.

<sup>82</sup> Frimodt-Möller, ‘Medical Missions and the Indigenous Churches’: 108.

dissemination, were common within much of the missionary discourse.<sup>83</sup> The words of one proponent summarize well not only their low assessment of understandings of health, but conditions of ill health they believed were a direct consequence of ignorance: "... The advancement of medical science in countries where ignorance in regard to it, and where a medical practice, founded on grossly erroneous principles, entails a fearful amount of suffering on the victims of disease in such countries".<sup>84</sup>

Further to this supposition was the justification for medical missionary work: to provide 'proper' understandings of medical science and health care.<sup>85</sup> Indeed, for some, the goal was no less than the introduction of a new medical system and way of thinking.<sup>86</sup> In a chapter justifying the role, and indeed what he felt was a vital need, for medical missionary work, one missionary doctor briefly addressed detractors and presented a classic understanding of the 'advance' of Western society in the 19<sup>th</sup> century:

Even in these days one sometimes hears it suggested that it would be better to leave the peoples in Africa and the East to the tender mercies of their own 'medical men,' who have knowledge of native remedies and the native constitution, and who can by their simpler methods achieve many remarkable cures. Such a view is based upon ignorance. It is true that there are certain native prescriptions which have great efficacy, and that in spite of seemingly hopeless conditions a wonderful cure is sometimes effected by the native practitioner. Unfortunately these cases are the exception....

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<sup>83</sup> See, J.T. Gracey, *Medical Work of the Woman's Foreign Missionary Society Methodist Episcopal Church* (Dansville, NY: A.O. Bunnell, 1881), 9-12; W.L. Thompson, in *The Medical Arm of the Missionary Service*, 4-5.

<sup>84</sup> Swan, 'The Importance of Medical Missions', in *Lectures on Medical Missions*, 91.

<sup>85</sup> Mary Janet Alexander, *The Voice of Pain* (Moultrie, Georgia: Privately Printed for the Author by The Observer Printers, Inc., 1942), 23, 38-39, 123. Note Alexander's point that it was not just non-Christians that were 'ignorant' regarding disease causation and treatment, but local Christians as well, 121.

<sup>86</sup> Benjamin Hobson, *An Appeal to the Religious and Benevolent Public on Behalf of a Proposal to Establish a Medical School for the Natives of China, in Connection with the Chinese Medical Mission at Hong-Kong*, (n.p., 1846), 3; Hobson, in *Meeting of the Edinburgh Medical Missionary Society, held 13 January 1846*. (Edinburgh: Miller and Fairly, 1846), 9.

The nineteenth century has, of course, seen an unprecedented advance in medical science in this country, and much that was superstitious or due to ignorance in medical practice has, during that period, been eliminated.<sup>87</sup>

It was this opinion of a superlative worldview, informed to a large extent by science and biomedicine, which led to the earnest attempt to fundamentally alter culturally informed understandings of illness and health care. Additionally, it should be noted that colonial authorities or ruling governments especially supported mission medicine when it was either cost effective for them, or as a wider effort to encourage the norms of Western health care understandings and practice.<sup>88</sup>

#### *Ending Culturally Inferior Elements*

The goal for many focussed on eliminating indigenous understandings of ill health causation and treatment – and the attached social apparatus – while at the same time introducing biomedical thought. For some, the physical health and disease environment were seen as a direct result of non-Western cultural norms.<sup>89</sup> Traditional doctors were almost always seen by the missionary spectators as inadequate healers, at best, and intentionally corrupt thieves or killers at worst.<sup>90</sup> The words of one promoter reflect the racial stereotyping, in the form of Social Darwinism, and the perception of inferior cultural understandings and practices, particularly with regard to traditional healers:

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<sup>87</sup> Henry T. Hodgkin, *The Way of the Good Physician*, (Edinburgh: The Foreign Mission Committee of the Church of Scotland / The Mission Study Council of The United Free Church of Scotland, n.d. [c. 1916]), 15.

<sup>88</sup> Such instances of governmental involvement and support of missionary medical work must be carefully analysed on individual cases, while also aware of these authorities' varying 'Native policies'.

<sup>89</sup> Miller, 'Medical Missions', in *Lectures on Medical Missions*, 24.

<sup>90</sup> Thomas Laurie, *The Ely Volume; or, Contributions of our Foreign Missions to Science and Human Well-Being* (Boston: American Board of Commissioners for Foreign Missions, 1881), 406-416; Hodgkin, *The Way of the Good Physician*, 16-28.

Medical missions are the only efficient opponents of the quackery which is intimately associated with religious superstition. Among the lower types of humanity in Africa, Polynesia, and aboriginal America, religion is quackery. The abject fear of the unknown on the side of the people, and the devilish cunning and malice of the sorcerers and the medicine-men or witch-doctors on the other, have given to the latter an incredible power for evil... The witch-doctors diligently foster these superstitions, and pretend to be able to find out by their incantations who the wizards and witches are. If the witch-doctor can not exorcise the sick person, the friends usually torture and kill the alleged wizard or witch.<sup>91</sup>

Exceptions to this rule are witnessed in examples like David Livingstone, the famous Scottish explorer/medically trained missionary; Livingstone was not simply genuinely interested in African traditional health practitioners as an intellectual exercise, but he himself was treated by some during his time in Africa.<sup>92</sup>

#### *Most Culturally Relevant*

Yet, even if the underlying motive was to work against traditional methods of healing and understandings of health, another reason for the propagation of medical missions centred on the fact that traditional healers in some non-Western cultures also had a significant religious role. The Rev. William Swan, a Scotsman who had served as an LMS missionary in Siberia in the first half of the 19<sup>th</sup> century, asserted that medical missionaries were most appropriate in that particular field: “as their own religious teachers were also physicians, they took it for granted that we too combined the two characters”.<sup>93</sup> This attempt to most fully adapt missionary strategy to the cultural setting – ultimately, to upend it – is a notable facet in the method and approach of mission endeavour during this period.

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<sup>91</sup> George E. Post, quoted in James S. Dennis, *Centennial Survey of Foreign Missions* (Edinburgh and London: Oliphant, Anderson & Ferrier, 1902), 192. Post was a Professor of Surgery at the Syrian Protestant College, with the ABCFM.

<sup>92</sup> Michael Gelfand, *Livingstone the Doctor* (Oxford: Basil Blackwell, 1957) 5-7.

## Civilising

### *Extending 'Civilisation'*

If one driving factor for medical missionary work centred on the attempt to suppress traditional methods of healing, an equally important and associated factor was the effort to propagate Western 'civilisation' or help 'the civilising process' amongst other societies.<sup>94</sup> Amongst other predominant cultural norms, such as Christianity, Western biomedicine was an important component of the wider drive to bring 'enlightened' understandings of the world to foreign lands.<sup>95</sup> One article from the medical journal, *The Lancet*, illustrates well one opinion of the celebrated role medical missionary work had in the British Empire's unique 'care' in helping to civilise peoples and regions:

"Imperial expansion" has its appropriate celebration in "Empire Day," and among the contributory forces leading up to the former and worthy of due commemoration on the latter is that of the Medical Mission. What that force has been, particularly in the later decades of the nineteenth century, can best be indicated by the word "circumspice." Wherever Great Britain has established a "sphere of influence" in regions savage or semi-civilised, tropical or subtropical, there she can point to the concurrent establishment of the means of rehabilitation, social and moral, prominent in which stands out the Church mission, reinforced by the medical coadjutor as its "right-hand arm."<sup>96</sup>

Some believed that they had been privileged by God with such learning, and that it was their responsibility to bring this knowledge to others.<sup>97</sup> In a prefatory

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<sup>93</sup> William Swan, 'The Importance of Medical Missions', in *Lectures on Medical Missions*, 104-105.

<sup>94</sup> W. Douglas Mackenzie, *Christianity and the Progress of Man As Illustrated by Modern Missions* (Edinburgh & London: Oliphant Anderson & Ferrier, 1898), 51-52.

<sup>95</sup> Miller, 'Medical Missions', in *Lectures on Medical Missions*, 17, 25-26; Thomson, *Medical Missions. A Prize Essay*, 5; Gordon, quoted in *The Lancet* (9 May 1863): 530; K.G. Fraser, 'Pioneer Medical Missionary Work in the Pagan Sudan', *SAO* March 1925, 64-66; J.D. Rheinallt Jones, 'Missionary Work Among the Bantu in South Africa', *IRM* 17 (1928): 175-185, particularly 177.

<sup>96</sup> 'Medical Missions', *The Lancet* 171 (6 June 1908): 1640.

<sup>97</sup> Thomas R. Colledge, Peter Parker, and E.C. Bridgman, *Suggestions for the Formation of a Medical Missionary Society, Offered to the Consideration of All Christian Nations, More Especially to the Kindred Nations of England and the United States of America* (Canton, China: October 1836), 8-9;

essay for the publication of a series of lectures on medical missions, William P.

Alison, then the Professor of the Practice of Physic at the University of Edinburgh, presented the view that the spread of Western medicine within a wider imperial effort was under God's care and probably His way of extending 'advanced civilisation':

... And we may hope that the benefits silently and steadily conferred on the natives of India by British justice, science, and art, dispensed under the guidance, and secured by the obligations of Christianity, may be the chief instrument in the hands of Providence for this regeneration of lost and nearly forgotten nations.

It is not assigning too much importance to Medical science or to the Medical art to assert, that of the temporal benefits which must thus precede and attend the extension of Christianity over the world, their influence on social happiness must be one of the surest and most powerful.<sup>98</sup>

For those like Alison, missionary medicine was a vital part of the dissemination of the wider notions of civilised thought and custom, which they viewed as an inherently good and Christian element,<sup>99</sup> over and against the 'evil' state of many non-Christian cultures.<sup>100</sup>

#### *Western Health and Hygiene*

While the phrase might well seem foreign to many in today's culture, the motto, 'cleanliness is next to godliness', was in fact used by backers of missionary work. Efforts to inform the public, through mission medical personnel, on a host of issues such as housing, sanitation, and clean water were a part of the overarching

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Rev. T.A. Gurney, 'The British Empire and the Kingdom of God', *Church Missionary Intelligencer*, quoted in *The Church of Scotland Home and Foreign Mission Record* no. 424, new series no. 151 (July 1897): 230.

<sup>98</sup> William P. Alison, 'Prefatory Essay', in *Lectures on Medical Missions*, xxvi.

<sup>99</sup> Ibid., xxi-xxviii; William Swan, 'The Importance of Medical Missions', in *Lectures on Medical Missions*, 92-97, 115-116; James Robertson, *The Medical Profession The Complement of The Christian Ministry*, 13, 20; John Lowe, *Medical Missions*, 147-169.

<sup>100</sup> William Brown, 'The Qualifications of a Medical Missionary', in *Lectures on Medical Missions*, 137.



drive to help civilise the ‘backward’ cultures.<sup>101</sup> In this period prior to the World Health Organisation or widespread governmental involvement with healthcare issues, medical missionary work was justified in what we might today identify as ‘proto-relief development’.<sup>102</sup> In an address promoting varying aspects of missionary medical work, one practitioner expounded on such work within rural areas of South Africa,

...It is in the district work that the greatest opportunities occur... [after treating a particular case within a village] the residents from a number of huts and possibly a number of families are before him. It is a great opportunity to preach the value of cleanliness, – to preach the need of ventilation in a hut, – to preach all the things he wants them to know about disease and health...<sup>103</sup>

These opinions on ‘proper’ sanitation and other matters of cleanliness and manners of hygiene are an important element in understanding the way in which Western hegemony tried to determine even the manners of ordering domestic life. And as products of their own cultural backgrounds, and further schooled in matters compounding the importance of such health related issues, there is really no surprise that medical missionaries, of all such people, would propound such ideas and see their righteous justification in propagating such matters.

## Professional

### *The Medical Missionary*

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<sup>101</sup> Dr. Annie Smith, ‘A Walk round the Wards of the Dow Memorial Hospital, Gujarat’, *News of Female Missions* (August 1902): 61; Miss Selkirk, *News of Female Missions* (April 1903): 27; Keen, ‘The Service of Missions to Science and Society’, 59-60.

<sup>102</sup> I am indebted to my conversation with Professor Gareth Griffiths for his insightful comments and help in further understanding elements of the medical missionary endeavour in light of other perspectives in post-colonial thought. He first mentioned to me the notion of “proto-relief development”.

<sup>103</sup> H.M. Bennett, ‘Field Work in Medical Missions’, *SAO* February 1940, 35-36.

In addresses, often specifically tailored to medical personnel, promoters of medical missionary activity commented on the professional expertise and widely varying disease environment a medico might likely encounter in ‘foreign’ lands.<sup>104</sup> In his lecture to a number of young medical men in Scotland, one speaker remarked on the extraordinary opportunities available: “For a truly pious medical man of a sound constitution and a Missionary spirit, China is the field, and the [Edinburgh] Medical Missionary Society the proper agent for placing him down and sustaining him upon it. To *such* a man the enterprise offers a career of brilliant achievement of the highest order.”<sup>105</sup> And for junior doctors, the opportunity to work in a health environment so different from what they were used to (often in circumstances in which they had very little supervision and sometimes forced to learn by trial and error) was presented as an attractive professional challenge.<sup>106</sup> In the best sense of such solicitation, these medical mission advocates believed that doctors and nurses would prove themselves even more able in their medical abilities upon their return to domestic service, having participated in the ‘righteous’ and professionally rewarding work in ‘foreign service’.<sup>107</sup>

#### *Place for Female Physicians*

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<sup>104</sup> One editorial in the prestigious *Lancet* went so far as to remark that the small number of medical missionaries would quite likely be prominently shaping the future of China, India, and Africa. See, ‘Medical Missions’, *The Lancet* (16 June 1888): 1213.

<sup>105</sup> Jonathan Watson, ‘The Duties of a Medical Missionary’, in *Lectures on Medical Missions*, 214 [emphasis his].

<sup>106</sup> G. Duncan White, ‘Medical Missions: The Quality of Doctors Needed’, *SAO* May 1924, 113-114. See also, William Swan, ‘The Importance of Medical Missions’, in *Lectures on Medical Missions*, 129-130.

<sup>107</sup> James Miller, ‘Medical Missions’, in *Lectures on Medical Missions*, 54-63.

In a period in which women were but beginning to break through the barrier into higher medical education, another complication encountered upon the completion of study centred on the establishment of a medical practice and community support.<sup>108</sup> Though not necessarily championed as a haven for female physicians, the role as a missionary doctor was certainly exploited by many emerging female medical professionals.<sup>109</sup> Women like Jane Waterston, one of the first Scottish physicians and a missionary to Central and South Africa, and Clara Swain, the first female doctor to serve with the American Methodist Episcopal Church in India, viewed the opportunity of medical work in the mission setting as ripe with wide prospects to practice their skill and knowledge in arenas with less interference than at home.<sup>110</sup> And in some mission organisations, female doctors became a very sizable portion of the medical missionary population. By 1900,<sup>111</sup> about one-fifth of the missionary physicians of the Free Church of Scotland were female, while the United Presbyterian Church mission had seven female doctors and seventeen male medical missionaries, whereas the Church of Scotland's Foreign Mission employed an equal number of mission physicians: six women and six men.<sup>112</sup> With the concurrent rise of modern nursing during the latter half of the 19<sup>th</sup> century, and its

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<sup>108</sup> See the brilliantly insightful short story, first published in 1922, by Sir Conan Arthur Doyle, on the very subject of the difficulty of a female physician establishing her practice within a small town at the end of the 19<sup>th</sup> century. Arthur Conan Doyle, 'The Doctors of Hoyland', in *Tales of Adventure and Medical Life* (London: John Murray, 1963), 177-189.

<sup>109</sup> 'Female Medical Work', *Helping Hand*, quoted in *CE* January 1886, 12.

<sup>110</sup> Mrs. Robert Hoskins, *Clara A. Swain, M.D.* (Boston: Woman's Foreign Missionary Society Methodist Episcopal Church, 1912). For more on Waterston, see chapter 2 in this thesis.

<sup>111</sup> In the following figures, I have taken the liberty of combining the male and female associations, where otherwise applicable, under the name of the broader denominational organisation.

<sup>112</sup> Dennis, *Centennial Survey of Foreign Missions*, 31-32. The new Foreign Missions of the United Free Church of Scotland (which was formed in November of 1900) first reported, in 1901, 21 male medical missionaries and 13 female.

gendered association, female nurses also became an ever increasing presence on the mission field.

#### *Special Role for Women working with Women*

If female doctors found an occupational opening in the sphere of missions, a key aspect of their effort in the field centred on working with fellow women, a portion of the population who were often marginalised, especially regarding health care.<sup>113</sup> Another element in the promotion of female medical missionary work centred on their ability to access portions of the population which male missionaries (medical or not) were restricted from encountering.<sup>114</sup> The most notable example came from India, and the *zenana* system<sup>115</sup> which led to the establishment of missionary activity organised explicitly for this purpose. In a short piece at the end of the 19<sup>th</sup> century, in a Church of Scotland missions journal, Agnes Bow wrote vigorously on the vital position available to female medical missionaries and what they believed was their pivotal role in empowering Indian women:

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<sup>113</sup> Emma Tucker, 'Experiences of a Doctor in North China', in *Medical Needs of Chinese Women and Children* (Boston: Woman's Board of Missions, 1919), 3-8.

<sup>114</sup> Gracey, *Medical Work*; John Lowe, *Medical Missions*, 175-198.

Antoinette Burton has maintained that the Zenana phenomenon, as it related to the British Empire and perceptions of it within Victorian Britain (which were not always accurate) was crucial in the breakthrough for female doctors in the United Kingdom. See, Burton, 'Contesting the Zenana: The Mission to Make "Lady Doctors for India," 1874-1885', *Journal of British Studies* 35, no. 3 (July 1996): 369.

<sup>115</sup> *Zenana* is a Hindi term, probably derived from Persian, referring to the segregation of the females of a household to a certain portion of the house/compound. This manner of secluding the women of a household was also common in some Moslem traditions, which missionaries adapted their work to. A few prominent denominational missions, and a couple independent societies, organised specific *zenana* organisations and operations for female missionaries. There were, for example, The Church of England Zenana Missionary Society, the Zenana Bible and Medical Mission, and the Ladies' Association for the Support of Zenana Work and Biblewomen in India, in connection with the Baptist Missionary Society. Indeed, the Zenana Medical College was even begun in London, to train women for work, such as nursing, dispensing, or midwifery.

Only medical women can reach the large majority of the women in India. After their very early marriages they are taken to the husband's family home, where the mother-in-law reigns supreme. The young wife is entirely controlled and overlooked by her mother-in-law.... In such Zenanas the visit of a medical Christian woman is the dawn of better things – the realisation of life with hope, and hope of life without suffering.<sup>116</sup>

In an age which witnessed increased attention to female roles in prominent positions of social action in Western society, such as the suffrage movement or social organizations such as the Red Cross or the Salvation Army, there was an increased awareness of the role in trying to transform the health and lives of fellow women around the world through the work of medical missions.

#### *Training Indigenous Medical Personnel*

If the renowned Rev Dr Peter Parker campaigned for more medical missionaries, as well as for the training up of native medical personnel in 1841,<sup>117</sup> by the time Henry Hodgkin, a Friends missionary physician in China, wrote on the subject 75 years later, a greater emphasis was placed on the transmission of medical expertise to the indigenous population by medical missionaries, not simply more Western medical missionaries:<sup>118</sup>

The time has now come when we pay even greater attention to the development of native agency.... Our whole policy rests upon the assumption that we are primarily concerned with the building of a native church, that the work in each land must in the end be done by its own people, under their own control and with their own funds, and that the foreigner is simply preparing the way for this time. Every method we use and every step we take ought to be clearly related to this aim.

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<sup>116</sup> Agnes C. Bow, 'Female Medical Missions', *News of Female Missions* (November 1899): 83-84.

<sup>117</sup> Peter Parker, '[Letter] to John Abercrombie', in *Statements Respecting Hospitals in China*, 3-8.

<sup>118</sup> James Miller, in the middle of the 19<sup>th</sup> century, explicitly expresses the nuanced view of what was otherwise a very long lasting reality in medical mission education and practice: the training of indigenous medical practitioners, but continued supervision and management by Western missionary personnel. "Native missionaries will be trained, both for purely missionary work and for Medical Missions... *But they are not enough of themselves*.... The Sepoy fights gallantly, *but he must be led*; - he is ready to charge up to the cannon's mouth, but his officer must be there before him. And so the native missionary, *under the guidance* and companionship of his European brother, will doubtless prove faithful and dauntless..." [emphasis mine]. Miller, 'Medical Missions', in *Lectures on Medical Missions*, 50.

The work of medical missions is no exception.<sup>119</sup>

His enthusiasm for the education of a variety of medical professionals – doctors, nurses, medical assistants, health evangelists – was widely shared by others throughout the 19<sup>th</sup> and early 20<sup>th</sup> centuries.<sup>120</sup>

Another writer expanded on this idea of native trained medical personnel and both the long term importance and implications of this professional class being Christians, when colonial involvement ceased:

The question is not so much whether there is to be any medical profession in the countries concerned, for there will be some sort of profession eventually, but whether that profession shall be predominantly one of three types: poorly trained in scientific medicine; well trained in scientific medicine, but with no association with religion and with a minimum of ideals; or well trained and with a strong leavening of Christian ideals, including many definite Christian practitioners.

The third is, of course, our aim. We covet the future medical profession of these countries as a friend and ally of the national Church... A good medical school constitutes one of the most exacting tasks in the whole missionary enterprise...<sup>121</sup>

In addition to such long term interests, others were more concerned with contemporary realities. One opinion contended that medical missions were further justified and greatly helped, not simply with additional personnel but in the associated reduced costs of locally trained workers (as opposed to Western missionaries), through the training of indigenous workers.<sup>122</sup> Professional reasons

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<sup>119</sup> Henry T. Hodgkin, *The Way of the Good Physician*, 65.

<sup>120</sup> Miller, 'Medical Missions', in *Lectures on Medical Missions*, 49-50; 'The Edinburgh Medical Missionary Society', *The Lancet* (20 March 1886): 560; W. Burns Thomson, *Reminiscences of Medical Missionary Work*, 146; Lettice Bernard, *News of Female Missions* (February 1899): 13; Hodgkin, 65-79; Moorshead, 'The Church in the Mission Field and Medical Missions', 283; C. Frimodt-Møller, 'Medical Missions and the Indigenous Churches': 102-110.

Sir William Muir, who, as Lieutenant-Governor of the North-West Provinces in India during a portion of the late 19<sup>th</sup> century, provided for free education for some students at the Edinburgh Medical Missionary Society instituted Medical School at Agra, demonstrates the often close connection between colonial governments and the medical missionary cause.

<sup>121</sup> E.M. Dodd, 'Medical Missionary Policy – II', *IRM* 18 (1929): 592.

<sup>122</sup> R. Fletcher Moorshead, 'The Church in the Mission Field and Medical Missions', *IRM* 5 (1916): 285. This argument had its roots in Moorshead's more central argument that the missionary *medical*

were indeed an important aspect of the medical missionary justification for training indigenous workers. For in so doing, the medical missionary enterprise, while not directly displacing or substituting traditional aspects of healing and traditional doctors (either through Western medicos or Western-trained indigenous medical personnel), helped craft a new class of workers in an increasingly globalized world.

## Medical

### *Physical Well Being*

One of the most obvious arguments for the support of medical work within the missionary cause which centred on the very essence of such work, it nearly goes without saying, was the promotion of physical healing through medical work. At the most basic level, medical missionary work was supported because it was believed to save people who would otherwise die, or at least relieve suffering to a greater extent than otherwise possible.<sup>123</sup> If some felt the medical aspect of a mission an auxiliary tenet, that is to say, wholly separate from the penultimate aim of missions (preaching ‘the Gospel’ for conversion to the Christian religion, or the ‘the saving of souls’, for example), its purpose was nevertheless clear.

In his Presidential Address to the American Baptist Missionary Union in 1906, William Keen, then Professor of Surgery at Jefferson Medical College of Philadelphia and a widely respected leader in the medical field, captured the

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*aspect* had to be part of the larger hand-over of the overarching missionary endeavour to the indigenous church, and that the indigenous church ought to take on greater responsibility in this realm.

<sup>123</sup> William P. Alison, ‘Prefatory Essay’, in *Lectures on Medical Missions*, xxvi-xxvii; Jonathan Watson, ‘The Duties of a Medical Missionary’, in *Lectures on Medical Missions*, 196-197.

prevailing sentiment for the promotion of basic mission medicine amongst foreign peoples who were deemed otherwise inaccessible to ‘proper’ medicine.

The ravages of disease, as a result of ignorance, filth and superstition, inevitably caused attempts to teach the first principles of sanitation often combined with elementary medical treatment, and hence the medical missionary, the hospital, the trained nurse and other agencies to ameliorate the physical sufferings and suppress the physical vices of the heathen world.<sup>124</sup>

He went on to cite some of the most notable medical techniques and treatments introduced to these regions, such as Western methods of anaesthesia, vaccination, and antiseptic surgery.<sup>125</sup> Medical missionaries themselves advocated their work as the only available way of introducing medical concepts and understandings of health which would otherwise be unavailable to local populations.<sup>126</sup>

#### *Imperative to Spread Biomedical Knowledge*

In a related manner, there was also a belief that the very techniques and advances in biomedicine during this period were God’s blessing upon the ‘Christian’ West. Some held the conviction that they were thereby obligated to extend the fruit of such progress to those in societies whom they believed were under-privileged.<sup>127</sup> Frimodt-Möller, for instance, provides his reckoning of the providential elements arranging worldwide events:

It cannot, therefore, be a mere coincidence that the opening of the doors of the non-Christian world to the entrance of the Gospel practically coincides with the great discoveries of modern surgery and medicine, which have placed in the hands of the Church a new power of healing never seen since the earthly days of the Lord...

... Not only did our Lord give a new power of healing to His Church at the same time that He opened up the non-Christian world to the entrance of the Gospel, but also, as soon as it was possible to make use of the new power of healing, He called into existence the World’s Student Christian Federation, and through this movement

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<sup>124</sup> Keen, ‘The Service of Missions’, 53-54.

<sup>125</sup> Ibid., 58.

<sup>126</sup> R. Fletcher Moorshead, ‘The Church in the Mission Field and Medical Mission’: 282.

<sup>127</sup> James L. Maxwell, Jr., *Savages: Sick and Sound*, passim.



hundreds and hundreds of young men and women, to make use of these great opportunities and to go out and proclaim the kingdom of God through the act of healing.<sup>128</sup>

Such rationales for the impetus of mission medicine viewed the advances in medical knowledge and techniques of their modern age with great optimism, confident in its wide dissemination and reception in foreign lands.<sup>129</sup>

## Mission-Related

### *Care of Fellow Missionaries*

Throughout the 19<sup>th</sup> and early 20<sup>th</sup> centuries, missionaries died of diseases and health-related problems in large enough numbers that it led to some regions, such as the West African coast, to become colloquially known as ‘The White Man’s Grave’.<sup>130</sup> Understandably, the health of missionaries was of noted concern to missionary societies and interested parties in the domestic sphere.<sup>131</sup> At the 1910 World Missionary Conference in Edinburgh, the ‘Findings of the Medical Conference’ (from a study conducted by the Association of Medical Officers of Missionary Societies) were presented, and reported that more than 60% of the missionaries who had died while overseas, in the period from 1890-1908, had

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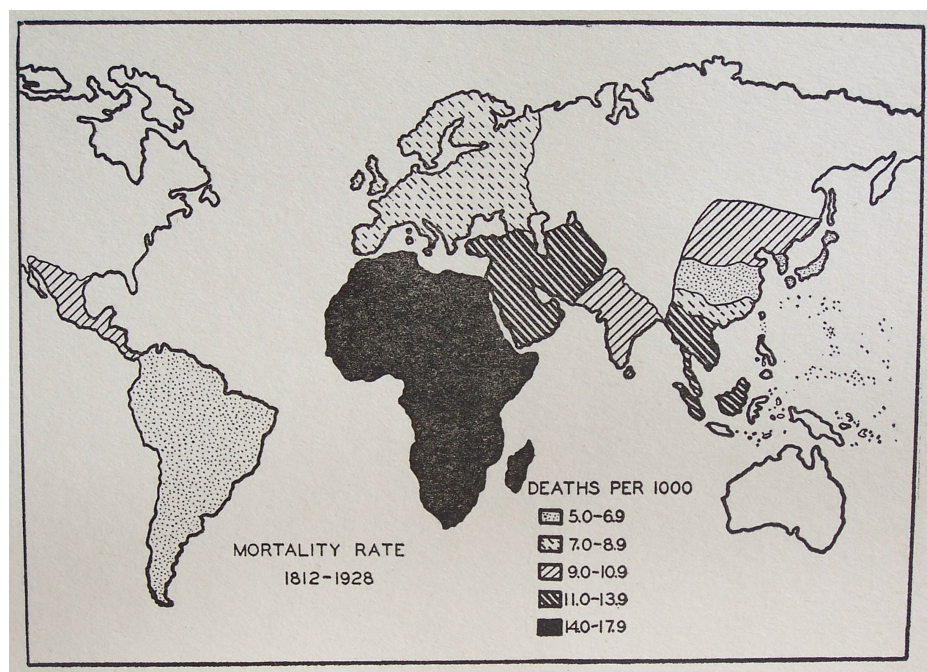
<sup>128</sup> C. Frimodt-Møller, ‘Medical Missions and the Indigenous Churches’: 105. This echoes the earlier expression voiced above in the chapter, but is much more telling, due to the further advances in medical science and techniques (nearly 80 years after the quotation above, in the above Spiritual/Theological subsection on ‘Understandings of Time’)

<sup>129</sup> William Brown, *Address to Students at the Conversazione of The Medical Missionary Society* (Edinburgh: John Grieg & Son, 1865).

<sup>130</sup> As Dr Jack Thompson has related in personal conversation, a Scottish missionary acquaintance of his, going out in the first half of the 20<sup>th</sup> century, was encouraged by the Foreign Mission Committee to include a shroud in the materials to be shipped down to Africa.

<sup>131</sup> John Lowe, *Medical Missions*, 170-174; J.G. Vaughan, ‘Medical Missionary Policy and the Health of Missionaries – I’, *IRM* 18 (1929): 584-589. Vaughan’s piece centred on the need for greater preventative health education for missionaries.

perished from ‘preventable diseases’.<sup>132</sup> Accordingly, even non-medical missionaries were encouraged to obtain medical training of a high enough standard, “in medicine, surgery, and the allied sciences” not only for their own health, but for the well being of their fellow missionaries.<sup>133</sup>



‘The average mortality rate for the whole period of missionary service of the four denominations with reference to various fields of work.’

This map was published in 1933 to demonstrate the mortality rate for missionaries from four American mission societies (Presbyterian, Baptist, Methodist and the American Board), from the period of 1812-1928. While including data from a rather early date in its statistical survey, it nevertheless demonstrates the importance of missionary health to those involved with the missionary venture in the 20<sup>th</sup> century.<sup>134</sup>

<sup>132</sup> *World Missionary Conference, 1910: Report of Commission IV: The Home Base of Missions* (Edinburgh: Oliphant, Anderson & Ferrier, 1910), 286, 290. While some of these so-called ‘preventable diseases’ may have been treated by Western medicine at the time, the fact remains that they could not procure complete healing for such common diseases as Tuberculosis at this time.

<sup>133</sup> *World Missionary Conference, 1910: The History and Records of the Conference*, 116.

<sup>134</sup> William G. Lennox, *The Health and Turnover of Missionaries* (New York: The Methodist Book Concern, 1933), frontispiece.

With such health problems, one of the pre-eminent reasons for a strong medical missionary presence was for the care of fellow missionaries.<sup>135</sup> E.M. Dodd, in a piece on mission policy, drew attention to missionary societies' responsibility to the health of their missionaries by remarking that the medical missionary's duty was twofold: "toward the people of the land, and toward their own associates as health and sanitation officers and family doctors."<sup>136</sup> He went on to remark on the ideal realm in which a medical missionary would function overseas:

... A strong case can be made out for the principle that all missionary families should be within reasonable reach of competent medical attention. We are not considering emergencies or temporary situations, but average sustained conditions; nor are we considering regions where medical attention for missionaries other than that from their medical associates is available.<sup>137</sup>

#### *Most Holistic and Far Reaching Method*

In the minds of some enthusiasts, the medical mission was sometimes upheld as the most effective method of missionary strategies. For, the medical missionary, it was argued, cared for the body as well as the soul, whereas the cleric or evangelist was more typically concerned only for the soul. In this rationale, the medical missionary was viewed as a much more holistic missionary.<sup>138</sup> In addition, his or her impact was thought to be much further reaching – indeed, multiplied – when compared to a more traditional missionary. Supporters of the medical mission cause felt that, in addition to a patient's telling of their successful treatment and the

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<sup>135</sup> Laurie, *The Ely Volume*, 416.

<sup>136</sup> Dodd, 'Medical Missionary Policy – II': 590.

<sup>137</sup> Ibid.

<sup>138</sup> Wilson, 'The Sacredness of Medicine as a Profession', in *Lectures on Medical Missions*, 224-227. Wilson elsewhere argued that the patient was also much more likely to speak to a physician who had

kindness of the missionaries, literature (such as a tract or Bible) was widely disseminated amongst villages upon their return home – former patients thereby becoming de facto evangelists.<sup>139</sup> In a certain manner of speaking, some proponents seemed to think that the vehicle of medical missions was not only of greater whole care for individuals with whom the missionaries interacted, but that there was potential for a much wider impact due to their presence. One might even suggest that there was a feeling amongst some proponents that the sending society was getting ‘more for its money’ with a medical missionary.

#### *Psychological Comfort & Mission Strategy*

Additionally, it seems appropriate to recognise the impact that a medical missionary had on a particular mission station itself, especially in a remote setting. The presence of a medical doctor brought with it an air of legitimacy and access, albeit limited, to Western health care norms<sup>140</sup> (no matter the fact that in many cases such doctors were virtually helpless in a battle against many illnesses<sup>141</sup>). Particular mission policies, or the opinions of some leaders, seemed to hinge on aspects of a medical missionary presence. One particular case from the Universities’ Mission to Central Africa, regarding the impact of the presence and condition of women at remote mission stations, helps demonstrate this. In his history of this mission’s first

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been treating him about spiritual matters than a clergyman he or she had never met. See, Wilson, in *Meeting of the Edinburgh Medical Missionary Society, 1846*, 5.

<sup>139</sup> Watson, ‘The Duties of a Medical Missionary’, in *Lectures on Medical Missions*, 204-205; Lockhart, in *Conference on Missions Held in 1860 at Liverpool*, 102.

<sup>140</sup> Peck, in *The Medical Arm of the Missionary Service*, 50; Dodd, ‘Medical Missionary Policy – II’: 593.

<sup>141</sup> Alexander, *The Voice of Pain*, 32-33. Note this missionary doctor’s resignation when certain disease outbreaks occurred. With regard to plague: “One is almost helpless when an epidemic comes...”; and with regard to cholera: “Cholera and Death are almost synonymous terms.”

fifty years, A.E.M. Anderson-Morshead wrote that women often proved a difficulty for their leadership, writing that, “It has been difficult to employ them in Stations far inland, where in the hour of peril they must be a source of anxiety to those at the head of the Mission.”<sup>142</sup> Dr R.W. Crust, who had served on a Church Missionary Society board, was quoted as saying,

Women are quite as dauntless, quite as full of high enthusiasm, as men; but in savage countries they are exposed by the law of Nature to a double form of death.... It appears to me wickedness to expose them to such contingencies.... It should be a rule absolute that as regards Equatorial Africa, no women should be allowed to be sent to a Station in the interior.<sup>143</sup>

It was not just the isolation itself, but the sense of being trapped within the ‘barbaric and uncivilised Dark Continent’ without recourse to any aspects of Western societal norms or help – especially medical – which led to such conclusions as reached by Crust. Victorian notions of the fragility of women, thought to be particularly prone to such things as profuse nervousness and displays of hysteria in settings which men were believed to be largely immune, and the lack of access to Western medical doctors to treat such conditions sometimes helped create general mission policies. While not often explicitly mentioned within the missionary discourse, it is entirely appropriate to draw attention to how medical workers impacted wider mission policies, however small that may have been. Their presence at a station, especially when isolated, provided not only the physical merits of a trained medical woman or man, but also a psychological sense of safety and familiarity for both fellow missionaries as well as the community back home.

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<sup>142</sup> Anderson-Morshead, *The History of the Universities’ Mission to Central Africa*, 463.

<sup>143</sup> R.W. Crust, quoted in, *The History of the Universities’ Mission to Central Africa*, 464.

### *The Local Church and Expatriates*

While many were concerned about the health of missionaries themselves, another interest resided with the indigenous population that had converted to Christianity. For some, there was an especial concern for those that were now ‘within the Christian fold’. These backers of medical mission work were, at times, especially afraid that without proper medical attention, this group would be especially susceptible to leaving Christianity and perhaps therefore mitigating possible future conversion within the wider population.<sup>144</sup> With two intended groups of people to practise and minister to – the indigenous Christian population and fellow missionaries – there was yet another community for whom the medical missionary was important. Expatriates, such as traders, soldiers, and farmers, were not often an explicitly targeted mission group, but their presence in foreign lands, and the lack of access to Western biomedical practitioners was seen as a further justification for the medical missions.<sup>145</sup>

### Humanitarian/Benevolence

#### *Humanitarian Concern*

While religiously based arguments may have made up a majority of claims for the missionary use of medical means, another argument for their work centred on

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<sup>144</sup> Maxwell, Jr., *Savages: Sick and Sound*, 57.

<sup>145</sup> Watson, ‘The Duties of a Medical Missionary’, in *Lectures in Medical Missions*, 203.

It might be noted that Scottish mission work in India was aimed at one such grouping within the late 19<sup>th</sup> century: Scottish soldiers. In a sense, it was a kind of ‘Home Mission’ in ‘Foreign Lands’, quite similar, albeit to a different grouping, to the Norwegian Sjømanns Kirken, (Seamen’s Church) which worked amongst fellow Norwegian sailors, seafarers, whalers, and fishermen, from as far afield as Leith, Scotland, to Durban, South Africa.

aspects of the humanitarian or benevolent nature of their motivation for this work.<sup>146</sup>

This line of reasoning seemed to be especially directed toward individuals with the wider medical or philanthropic community; that though they themselves (the audience) may not be evangelical Christians, these medical missionary backers (typically either a medical man or missionary themselves) hoped that they would still help support the scheme because it was a compassionate venture.<sup>147</sup> As both medically minded and in the spirit of benevolence, it was hoped to be, and be seen as, a worthy enterprise in and of itself. While it should be noted that the evangelistic/conversion/religious language may not typically have been used to the same degree within this format, it did not necessarily detract from the Christian nature of the mission. A striking example of this occurred with the establishment of a mission hospital in Hong Kong, led by the physician Benjamin Hobson, of the London Missionary Society. The hospital was paid for by American and British merchants at a cost of \$5,000, not the Christian ‘home base’ in Britain, and known locally as the ‘Benevolent Healing Hospital’. The hospital’s manifesto further relates the munificent tone coupled with Christian teaching:

Those that are very needy have money allowed for rice, and there is no tampering with the high to the neglecting of the poor; but all are treated alike, as belonging to one family. Diseases of the eye, ear, skin, with the internal and external disorders of the body, are understood and cured gratuitously, without money or price....

The surgeon and master of the house wishes all the patients to assemble each morning, with one mind, to worship the true God, and carefully hear the pure principles of the heavenly doctrine explained and enforced... The object of

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<sup>146</sup> David Hardiman, ‘Introduction’, in *Healing Bodies, Saving Souls* (Amsterdam: Rodopi, 2006), 48-49.

<sup>147</sup> Hobson, *An Appeal to the Religious and Benevolent Public*. Note Hobson’s tone and language throughout this appeal, not referring to the Bible, for example, but to “the inspired volume” (p. 5), and his concluding remarks to “his brethren of the medical profession, and the affluent and charitable...” (p. 6).

establishing this hospital is to exhibit the benevolent character of the doctrines of Jesus...<sup>148</sup>

Another missionary doctor working in China wrote of the vital need for Christians to be involved in philanthropic work overseas (which is how he viewed the medical work of missions), and that such humanitarian work ought not to be separated from Christianity. His view seems to combine both of the polar ends within this subject:

When the Church takes no part in philanthropic effort the world says, 'The Church talks at men's souls and lets their bodies rot away,' the truth being that one of the Christlike characteristics of Christianity is gone; while to have hospitals and asylums apart from Christianity, this is to pick the fruit and reject the tree from which it grew.<sup>149</sup>

### *Benevolent Societies*

Amongst the many changes and transformations in the 19<sup>th</sup> century, the shape, form, and justification of the medical mission endeavour must be seen alongside the rise of a number of benevolent societies as well as the Social Gospel movement. Everything from Temperance movements and 'Poor Relief' to groups like the Red Cross played important roles in addressing 'social ills'. Unsurprisingly, many of these had Christian roots, and were often (though not exclusively) begun or run by those from the middle and upper classes.<sup>150</sup>

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<sup>148</sup> *Manifesto of the Medical Missionary Society's Hospital in Hong-Kong*, quoted in *First Report of the Glasgow Association in aid of Chinese Medical Missions*, (Glasgow:1846), 8.

At the same time there were certainly those who detracted from the 'medical missions as simply humanitarian work' viewpoint, maintaining that the medical work ought to be, and be thought of, as just as central to missions as evangelistic or educational work. See, Moorshead, 'The Church in the Mission Field and Medical Missions', 279-280.

<sup>149</sup> P.L. McAll, quoted in Moorshead, 'The Church in the Mission Field and Medical Missions', 281. McAll was with the London Missionary Society at the Hankow station, and this quote came from an article he wrote in the mission based journal, 'The Philanthropic Work of Foreign Missions in China', *China Medical Journal* (May 1911).

<sup>150</sup> Kenneth Scott Latourette, *A History of Christianity: Reformation to the Present*, Volume 2, Revised Edition (Peabody, Massachusetts: Prince Press, 1997), 1185-1188, 1198-1200, 1263-1264.



Amidst these varied benevolent movements were medical missions, both domestic as well as foreign, which placed a special emphasis upon providing medical help for the poor. One of the earliest and most important of these organisations was The Edinburgh Medical Missionary Society,<sup>151</sup> founded in 1841 by a veritable local cadre of medical, civic, religious, and business leaders, at the instigation of the American missionary physician, Dr Peter Parker. The Edinburgh Medical Missionary Society operated both in helping to educate and train up students for medical missions, namely in the Cowgate area of the Scottish capital (and support them while in the foreign field), as well as to provide for the medical needs of the poorest members of society.<sup>152</sup> This emphasis upon benevolently helping the urban poor was a central aim and justification for a number of medical missions. Take, for example, the mission statement of The Florence Medical Mission: “[It] has for its object (like the Medical Missions in London, Paris, &c.) to bring the sick of the poorest classes under the influence of the Gospel, whilst their bodily ailments are relieved by the medical advice and the remedies which they receive gratuitously at the Mission.”<sup>153</sup>

#### *Moral Influence of ‘Christian’ Charity*

Within portions of Scotland a debate had raged in the middle of the 19<sup>th</sup> century over the issue of how to best help the poor and destitute, especially within the increasingly cramped and unhealthy urban centres, such as Glasgow. Amidst the

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<sup>151</sup> The organisation was first called, The Edinburgh Association for Sending Medical Aid to Foreign Countries, and was changed to EMMS the following year. EMMS continues to this day, operating as Emmanuel Healthcare.

<sup>152</sup> John Wilkinson, *The Coogate Doctors* (Edinburgh: The Edinburgh Medical Missionary Society, 1991); *The Fifth Annual Report of the Glasgow Medical Missionary Society, 1872*, 1-16.

<sup>153</sup> Thomas A. Roberts, 2<sup>nd</sup> *Repor; Florence Medical Mission* (Florence: G. Barbèra, 1883), 3.

debate came the example championed by Dr Thomas Chalmers, who was to later lead the breaking away from the Church of Scotland, establishing the Free Church of Scotland in 1843, in what was popularly known as ‘The Great Disruption’.

Chalmers’ church-based initiative for poor-relief centred on the distribution of aid to the ‘legitimately working poor’ within the parishes by church officials, while not promoting habits or lifestyles (i.e. laziness, drunkenness, gambling, cheating) they deemed ungodly. In this view, simply giving away food or money, was not believed to help people as it might encourage undesirable attributes.

In a similar way, one author, from this same Scottish context, propounded medical missionary work because he believed that it was the most beneficent form of philanthropic work. In his opinion, mission medicine did not exacerbate undesirable traits or ungodly characteristics in the people it helped:

It is worthy of special remark, that while our Lord exerted His miraculous power only upon two occasions in feeding the hungry, He was constantly and everywhere putting forth His divine energy in the healing of diseases. A lesson seems to be taught us in this fact in accordance with the highest wisdom, and which has been thought to be a discovery of modern political economy, namely, that we should rarely and cautiously interfere with our charities in a way that may tend to foster idleness and improvidence, but may freely expatiate in beneficent deeds upon objects to whom our charity must be an unmixed blessing. Our curing the blind and the lame has no tendency to *multiply* such objects for the exercise of our charity, but to give food and clothing may, if not wisely managed, both encourage sloth and increase the spirit of beggary – multiplying the objects that need relief, and thus increasing the evil it is intended to remove.<sup>154</sup>

Such an argument for the medical missionary cause probably played well to the ears of many middle class potential financial sponsors within Scotland during that period.

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<sup>154</sup> Swan, ‘The Importance of Medical Missions’, in *Lectures on Medical Missions*, 127.

## International Relations

### *Trade Benefits*

If some of those involved in the missionary movement viewed the medical work as a tool in gaining greater access for the more explicitly religious/spiritual work of conversion, another opinion viewed it as a way of opening up foreign societies to opportunities, such as trade. Writing in 1898, in a section of a chapter entitled, 'The Missionary as Pioneer', W. Douglas Mackenzie, then a professor at Chicago Theological Seminary, seemed to imply that these, "missionaries [who] have proved themselves of great service to mankind" by their medical work ought to be applauded by Western traders and other business people for the emerging markets they opened up.

As a matter of fact, the worst kind of traders precede the missionary; the best kind almost always come after him.

It is worthy of record that it has in several instances been reserved for the medical missionary to open the way into countries which had strenuously resisted the approaches of civilised communities. Into Siam, Corea, [sic] and Cashmere, for example, scarce a ray of light from the Western world could find its way until the medical missionary daringly entered and touched the needs of men with his merciful hands. His power to help human beings in the hour of their greatest distress... has over and over again broken down national prejudices and led to the emancipation of a people from the thralldom of isolation.<sup>155</sup>

### *Aids Western Reputations & Fosters Relations*

In a similar way, other advocates of medical missions combined the religious aims to wider aspects of the colonial endeavour. Writing in the middle of the 19<sup>th</sup> century, James Miller maintained that Britain had profited greatly from their worldwide imperial expansion ("what vast heaps of Indian gold have been borne away to increase our nation's prosperity") and that the medical work of the mission undertaking ought really to be seen, and supported, as a benevolent aspect of the

British presence in foreign lands.<sup>156</sup> An American missionary physician went further, arguing that it was the medical missionary presence within China which was the only counterweight holding back Chinese rage with Western interference:

The medical missions are a corrective to the wrongs we are inflicting upon these peoples. Where now you hear of a riot in China, you would, but for medical missions, hear of an extermination or of a general massacre; and for one expedition that you now send out you would have to send out two.<sup>157</sup>

Proponents thus concluded that on the one hand, if colonial native subjects sometimes felt the wrath of imperial powers, medical missionary work could be championed as the kind and compassionate recompense of Western presence, while at the same time helping to stay the hand of hostile anger toward problematic Western colonial or business interests.

Furthermore, it counteracted the unchristian-like behaviour and ways of those that some people may have encountered, who, though perhaps not calling themselves ‘Christian’, were seen that way by the native population.<sup>158</sup> One speaker on the topic passionately asserted:

It makes the heart of the missionary sad indeed, to see his work day by day undone by the wickedness and debauchery of these sailors... When the Chinese see, for instance, our sailors on leave ashore on the Sabbath-day getting drunk, going into the various villages, and by their violence and wickedness setting the minds of the people against them, they naturally say to us – “You teachers come and preach the Gospel of Jesus Christ; do you call these men Christians? Is it to make us men like these that you preach to us the Gospel of Christ?” And what can we say in reply?<sup>159</sup>

In this justification for medical missions, the beneficent medical work was perceived as having a way of undoing the malevolent witness and work of other Westerners –

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<sup>155</sup> Mackenzie, *Christianity and the Progress of Man*, 53.

<sup>156</sup> Miller, ‘Medical Missions’, in *Lectures on Medical Missions*, 40-41.

<sup>157</sup> MacGowan, in *Conference on Missions Held in 1860 at Liverpool*, 276.

<sup>158</sup> Swan, ‘The Importance of Medical Missions’, in *Lectures on Medical Missions*, 121.

<sup>159</sup> Lockhart, in *Conference on Missions Held in 1869 at Liverpool*, 106-107.

humanitarian work that could not be matched by mission work of a more clerical nature. This critique of their countrymen is not especially surprising, given typical evangelical Christian opinion of their own societies' 'sins'.

Alternatively, another writer argued for the importance of medical mission work as one of the best opportunities, "to throw down the barriers that separate the nations, changing them from the attitude and spirit of enemies into the state and feeling of friendly members of the same great family..."<sup>160</sup> Such opinion viewed it as a means of bringing goodwill between nations and helping to establish greater understanding of the shared humanity between peoples of varying ethnic and cultural backgrounds.<sup>161</sup>

## Scientific

### *Spreading Scientific Understandings and Medical Techniques*

One of the central reasons employed for medical missionary work involved the specialized training and education of indigenous workers, especially in regions where it was well received by either the people or political authorities, such as Japan in the last quarter of the 19<sup>th</sup> century.<sup>162</sup> As remarked upon in an earlier section, another stronghold in medical mission education work was in China. Medical missionary educators like Drs Kenneth Mackenzie or Dugald Christie worked to train

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<sup>160</sup> Swan, 'The Importance of Medical Missions', in *Lectures on Medical Missions*, 92.

<sup>161</sup> See the examples used – particularly from the Near East, China, and Japan – in, Laurie, *The Ely Volume*, 408-409, 413-415.

<sup>162</sup> Dr J.C. Berry, working with the American Board, received such warm welcome that he helped open a new Nurses' Training School and Hospital in Kyoto to wide acclaim and reception. Berry, 'Medical Missionary Work in Japan', *CE* September 1894, 139.

For more on this topic, see the section above, 'Training Indigenous Medical Personnel', pp 26-28, and chapters 4 and 6.

up medical personnel, educated in Western biomedicine, and particularly in aspects of surgery. In the hopeful opinion of one writer on this subject, near the turn of the 20<sup>th</sup> century, the opportunity to essentially supplant Chinese understandings of health with Western biomedical processes was open to the West, if only they would supply the medical missionary scientist and educators to accomplish the task:

It is not [to] be forgotten that the absolute ignorance of anatomy and physiology on the part of the Chinese means that the whole question of a rational system of medicine for the empire lies open for handling. Not only so, but the only handling on any extended scale yet possible lies in the hands of Protestant medical missionaries.<sup>163</sup>

And as with broader pedagogical concerns, and efforts in ‘civilising’ other peoples and societies, another facet of the medical missionary enterprise rested with the broader aim of public health teaching and instruction. The results of such mission based public health care and education led one writer, early in the 1940s, to conclude that the efforts had been largely successful. This medical missionary even felt that the accomplishments in educating the masses in places like Africa, China, and India, in terms of medical care and health understandings, was greater than amongst the populace in portions of Britain.<sup>164</sup>

This period from the 19<sup>th</sup> to early 20<sup>th</sup> centuries must certainly be seen in continuity with the previous age of geographical exploration and new scientific ‘discoveries’ and findings. And indeed, even in the last several decades of the 20<sup>th</sup> century, many of the advances in the treatment of patients with leprosy as well as understandings of the disease itself are owed to missionary doctors. Paul Brand, who worked amongst leprosy patients in India, achieved great strides in both the surgical

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<sup>163</sup> ‘The Medical Missionary Conference in China’, *Medical Missions at Home and Abroad*, quoted in *CE* February 1891, 27.

realm as well as with the development of prosthetics and other medical treatments.<sup>165</sup>

Stanley Browne, an English doctor who served with the Baptist Missionary Society in the Belgian Congo and then with the Leprosy Mission in Nigeria and Andrew MacDonald, a Church of Scotland doctor who opened the famous Itu Leper Colony in southeastern Nigeria, became leading voices in leprosy study and advisory roles in later years.<sup>166</sup>

#### *Furthering Scientific Knowledge*

Yet it was not simply for the sake of the ‘uncivilised’ for whom medical missions was important. Of equal value was the potential knowledge and data that medical missionaries had the ability to transfer to Western authorities.<sup>167</sup> An Edinburgh Professor of Surgery saw great prospective benefits to the medical profession in the knowledge gained and transferred back to the West by medical missionaries – from new diseases and disease forms to “vast treasures of both the

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<sup>164</sup> ‘A Medical Missionary’, *The Medical Mission of the Church*, 2.

<sup>165</sup> For example, Paul W. Brand, ‘Tendon Grafting: Illustrated by a New Operation for Intrinsic Paralysis of the Fingers’, *The Journal of Bone and Joint Surgery* 43-B, no. 3 (August 1961): 444 – 453. In addition to his time in India, Brand worked at the Hansen’s Disease centre in Carville, Louisiana, in the United States, and became more well known in his later years for his more theologically minded writings, done in collaboration with Phillip Yancey.

<sup>166</sup> See, for example, the autobiographical and descriptive works of A.B. Macdonald, *Can Ghosts Arise? The Story of Itu* (Glasgow: The Church of Scotland Foreign Missions Committee, 1948), and *In His Name: The Story of a Doctor in Nigeria* (London: Oldbourne, 1964). Or, the more public health minded work, Stanley G. Browne, *The Diagnosis and Management of Early Leprosy for Medical Practitioners* (London: Leprosy Mission, 1975), or *Memorandum on Leprosy* (London: H.M. Stationery Office, [1977]).

I am greatly indebted to Murdo Macdonald, Ph.D., and Rachel Macdonald, M.D., for their insight and help in better understanding Hansen’s disease and some of the nuances of both the disease itself, as well as the political influences affecting treatment and understandings of the disease. They were both very patient in dealing with my elementary questions and, at times, comprehension.

<sup>167</sup> Swan, ‘The Importance of Medical Missions’, in *Lectures on Medical Missions*, 130-131. Swan, otherwise longwinded, was unfortunately very succinct in his thoughts here. But he did note three areas of learning which medical science stood to gain from inter-cultural interaction through the medium of medical missions: 1. New ideas on the philosophy of disease; 2. Gains to their *Materia*

vegetable and mineral kingdoms”.<sup>168</sup> Another medical professional, the superintendent of a missionary hospital in South Africa, wrote in a cautiously positive manner regarding some traditional healers, “It would be unfair, however, to condemn all witch-doctors. Some herbalists undoubtedly do good. The drugs they use are effective.”<sup>169</sup> He later went on to describe the potential contribution to science from their sphere of specialised knowledge, and candidly expressed a kind of medical epistemological envy:

There are also certain herbs they [African traditional healers] know of, which some of us would dearly like to have investigated by the Institute of Medical Science, but we don’t know what they are. For example, what concoction is applied to the meat of a beast that has died of anthrax, which apparently destroys the germs and their spores and makes it fit to eat, and how is it prepared? They know. We don’t.<sup>170</sup>

If viewed by some, especially within the colonial centres of power, as a support for the wider Western presence and trade in far off lands, medical missions was seen by some as a boon to the more specific subject of Western science. Medical women and men, more educated in the sciences than their clerical co-workers, were supported in part with the recognition that they provided a much greater opportunity to enhance the scientific knowledge base, especially as so many of these workers were on varying fringes of the scientifically ‘known world’. These scientists were therefore able to relay their findings – whether in the realm of new herbs, or traditional methods of healing used by the indigenous populations, or new diseases and cases of health and treatment. Dr Robert Nassau, the American medical missionary, though unreliable in his anthropologic evaluations, was credited with

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*Medica*; and The influence of climate, food, clothing, etc., upon health. See also, Watson, ‘The Duties of a Medical Missionary’, in *Lectures on Medical Missions*, 197-199.

<sup>168</sup> Miller, ‘Medical Missions’, in *Lectures on Medical Missions*, 38-39.

<sup>169</sup> H.M. Bennett, ‘Field Work in Medical Missions’, *SAO* February 1940, 34.

<sup>170</sup> *Ibid.*



introducing the Calabar bean, Kola nut, and the *Strophanthus* plant to Western medical circles.<sup>171</sup> And in the same way, emerging medical techniques and understandings were seen as a key element in furthering North Atlantic expansion within the wider world – missions included.<sup>172</sup>

In this support for medical mission work and learning, the transference of knowledge was bilateral; both to and from, both giving and receiving. Inextricably tied into modern Western history are the connected notions of advanced knowledge and technology, especially in the realm of scientific study, and the physical exploration by and expansion of these societies. Among the leading missionary-sending countries, notions of racial (with attached hierarchical structures) and societal differences emerged to a point at which, by the end of the 19<sup>th</sup> century, it was largely taken for granted that Western society was civilised – whereas most non-Western societies and ethnic groups were regarded as uncivilised – and that it was the duty of the ‘more civilised’ to be stewards of the process of ‘progress’; teaching their ‘advanced’ ways to more ‘deficient’ people.<sup>173</sup> While this aspect of the cross-cultural interaction played itself out, both outwith and within missionary spheres of influence, the concurrent aspect of retrieving and transmitting new knowledge back home was of additional importance, though often overlooked.

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<sup>171</sup> Keen, ‘The Service of Missions to Science and Society’, 58-59. The *Strophanthus* species was a source of arrow poison in portions of Africa and later used by Western medicine as a cardiac stimulant.

<sup>172</sup> *The Romance of Exploration and Emergency First-Aid from Stanley to Byrd* (New York: Burroughs Wellcome & Co, 1934). While a promotional piece for the Chicago ‘Century of Progress Exposition’, this book, published by the drug company, is an outstanding example of the connections often implicitly made between notions of progress, exploration, scientific/medical advances, and overcoming the perils of the natural world.

## Concluding Remarks

To be sure, the role of medicine within the North Atlantic mission enterprise changed dramatically during the period from the 1840s to the early 20<sup>th</sup> century. From a nearly non-existent state (when Rev. Dr. Peter Parker helped stimulate the establishment of the Edinburgh Medical Missionary Society in 1841<sup>174</sup>), Western biomedical thought and practice gained widespread approval as a legitimate, indeed very important, aspect of mission work.

As we have seen in this chapter, the motivations and rationales for the inclusion of medicine in the missionary endeavour were varied and multi-layered. And just as the aims and methods of various organizations and individual missionaries were plethora, the justifications used in the integration of missionary medicine were often highly nuanced. As such, this chapter was thematically arranged to demonstrate that some of the reasons given spanned a range of decades, finding a voice in different settings. Nevertheless, the nature of the rationale for missionary medical work was based upon broader cultural developments in the West during the century.

The changes in the field of medicine during the latter half of the 19<sup>th</sup> century were undoubtedly one of the greatest influences on its incorporation within the mission operation. As biomedicine increasingly became seen as one of the earmarks of the Western world's progressing state of civilization, the healing art was coupled

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<sup>173</sup> James L. Barton, *Human Progress Through Missions* (New York: Fleming H. Revell, 1912), 15.

<sup>174</sup> This can be rightly seen as one of the most important events, with the striking example of one of the earliest explicit medical missionaries, and the establishment of the first explicit medical mission organization.

with missionary work.<sup>175</sup> Wholesale changes occurred in biomedical thought, with the branch of learning itself increasingly integrating varying specialty areas of science (such as biology, anatomy, botany, chemistry, midwifery, materia medica etc.) during this period. The professionalization of medicine also allowed for its easier assimilation with mission work, especially as the practitioners of medicine held increasingly esteemed places within Western societies.<sup>176</sup>

With breakthroughs in new techniques, instruments, and treatments, both specialised attitudes as well as public opinion viewed the biomedical field as improving and advancing the state of mankind. Wholesale changes occurred in the realm of health-care, and concerns such as public health policies were adopted into the social conscience where they had not existed a couple generations earlier. It should therefore not be surprising that these cultural movements and medical advances influenced missionary policy and make up.<sup>177</sup>

The Scottish setting demonstrates this change rather well, especially in the locations of medical learning and research. Edinburgh, for instance, was the location for the Royal College of Physicians, Edinburgh, the Royal College of Surgeons, Edinburgh, and the Medical School of the University of Edinburgh, while also the seat for the Foreign Mission Committees of the Scottish Churches and the home of the influential and well respected Edinburgh Medical Missionary Society. As medical leaders were also involved within the decision making circles of the

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<sup>175</sup> Grundmann, *Sent to Heal!*, 45-51.

<sup>176</sup> In Britain, for example, the Medical Act of 1858 helped standardize the profession by mandating national criteria, as opposed to varied local measures, as it was previously.

<sup>177</sup> Ross, 'The Scottish Missionary Doctor', 89-90; Good, 'Pioneer Medical Missions in Colonial Africa', 1.

churches, it is not surprising that medicine increasingly found its way into the domain of mission work.<sup>178</sup> And with the increased presence of specialised locations of ‘healing’ (such as hospitals, sanatoriums, asylums) as well as the emergence of influential and well known Medical Officers of Health, like Sir Henry Littlejohn (active in his position from 1862 to 1908), the increased attention on public health and hygiene measures extended throughout society.<sup>179</sup> In improving health, modern biomedicine gained a most important footing within the wider circle of mission supporters during this period.

Yet the realm of medicine itself was not solely responsible for its integration into mission work during this time. For there was an overarching shift which took place within mission circles owing to changes of a theological nature. Fundamentally, the difference came when the pre-eminent focus upon the salvation of souls changed to an increased desire to relieve suffering and provide curative medical care as part of the wider expression of Christian charity.<sup>180</sup> The idea of ‘the Kingdom of God’, for instance, had always maintained a place within the Western Christian tradition. Yet changes took place within theological circles and church life during the 19<sup>th</sup> century which increasingly emphasised the Kingdom of God as a concern for contemporary social matters and programs. This expansion of the ‘social Gospel’ took varied forms, such as in the establishment of numerous humanitarian

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<sup>178</sup> Hokkanen, *Quests for Health*, 93-95.

<sup>179</sup> Dingwall, *Scottish Medicine*, 164-187.

<sup>180</sup> Gulnar Francis-Dehqani, ‘Medical Missions and the History of Feminism: Emmaline Stuart of the CMS Persia Mission, 1897-1934’, Position Paper No. 103 (Cambridge: Currents in World Christianity, 1999), 3. And this is without saying anything about the notion of taking Western ‘advances’ (i.e. biomedical knowledge and techniques) to the ‘primitive’ cultures and peoples of the world, especially Africans; see the insightful work done by Hokkanen, *Quests for Health* 101-121.

and benevolent societies.<sup>181</sup> It ought to come as no surprise, therefore, that it also expressed itself in conjunction with the rise of the missionary movement and imperial expansion during the latter decades of the 19<sup>th</sup> century, with many of the young medical missionaries-in-training wanting to engage in work that would promote goodness in the wider world.<sup>182</sup> In the words of the historian of missions and empire, Andrew Porter: “Increasingly the expression of humanitarian sympathies in the form of healing and support for the medical missionary came to be seen not only as a useful adjunct to the task of evangelism but as integral to Christianity itself.”<sup>183</sup>

Amidst this background of the overarching incorporation of medicine within the missionary effort, and indeed, the implementation of doctors, nurses, and hospitals as essential elements within the mission endeavour during the 19<sup>th</sup> century, the Lovedale mission in South Africa is all the more interesting. For though Lovedale was an important centrepiece for Scottish missionary work on the continent, and often the envy of other agencies for its size and influence, the mission was without any institutional medical presence, until the turn of the century. Thus, Lovedale provides an interesting illustration of what could, at first, be seen as having uniquely flouted the mission norm of this period, drastically postponing the integration of medicine with mission work (though, in fact, medical work was largely

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<sup>181</sup> Brown, *Providence and Empire*, 354-355.

<sup>182</sup> Hardiman, ‘Introduction’, in *Healing Bodies, Saving Souls*, 16.

<sup>183</sup> Porter, *Religion versus Empire?*, 312.

non-existent in nearly all mission work in the whole of southern Africa at this time<sup>184</sup>).

In the eventual establishment of the Victoria Hospital, the developed rationales and motivation for the inclusion of an enduring Western biomedical practice at the mission is very telling, especially vis-à-vis Africa and perceptions of African culture and medicine as innately inferior. While there were efforts by Westerners to provide medical treatment for black South Africans, their work reached an extremely small percentage of the wider population, especially as these efforts were largely relegated to towns and the black population was overwhelmingly rural at the time.<sup>185</sup> James Stewart, the longstanding Principal at Lovedale, had long wanted a hospital and missionary doctor, not simply to treat patients, but to teach medicine to a new order of African elites.

The institutional focus at Lovedale was certainly not waning in the 1890s, and educating black leaders had been a motivating factor in propounding missionary education there for over half a century. In addition to prominent black ministers and intellectuals, by then established partly through the work of the Institution, a new class of medically trained black professionals – able to be ‘properly’ trained by a professional doctor or nurse – were part of the purpose in proposing the advent of sustained medical work at the mission in the last few years of the 19<sup>th</sup> century.

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<sup>184</sup> This was due, in part, to the government’s efforts in establishing cottage hospitals for black South Africans, however ineffective they were for treating the whole of the population. Additionally, in the latter half of the 19<sup>th</sup> century, most mission agencies had concentrated their medical work in China and India, believing they didn’t need to ‘waste’ these valuable assets on the likes of ‘savage’ and ‘uncivilised’ Africans.

<sup>185</sup> Van Heyningen, ‘Medical Practice in the Eastern Cape’, in *The Cape Doctor*, 183-189.

Lastly, the rationale for medical work at Lovedale at this time echoed the earlier claims in this chapter related to Western perceptions of the inadequacy of non-Western ‘quackery’. Southern African traditional methods of healing, from practitioners to notions of disease causation, were roundly ridiculed by the white population, both within and outwith Lovedale.<sup>186</sup> Naturally, the backers of a strong medical presence at Lovedale believed that the only way to provide ‘superior’ medical treatment for these Africans (and demonstrate another feature of their civilization) was through the presence of a Western location of healing, the Victoria Hospital, and professional medical missionaries, British-trained and educated doctors and nurses.

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<sup>186</sup> J.E.B., ‘Medical Mission at Lovedale (Communicated)’, *CE* January 1893, 14.

## Chapter 2: The Early Medical Work of Lovedale and the Victoria Hospital

### The Establishment of Lovedale

The Lovedale mission, located in the town of Alice in the Eastern Cape region of South Africa, was one of the most influential mission stations in the whole of Sub-Saharan Africa. A product of Scottish missionary efforts which stressed the importance of education, this station impacted southern African societies in a variety of ways – culturally, religiously, missiologically, socially, etc.<sup>187</sup> R. Hunt Davis rightly recognized the wide impact the Institution had, not simply upon a generation of black South African elite of the late 19<sup>th</sup> and early 20<sup>th</sup> centuries – men like Walter Benson Rubusana, Pambani Jeremiah Mzimba, John Knox Bokwe, Simon P. Sihlali, John Tengo Jabavu, and especially Elijah Makiwane – but upon the wider divide amongst the black African populace through the Westernising process involved in such education.<sup>188</sup> In work related to this same period of the Institution's history, Leon de Kock has drawn upon the literature produced by this intelligentsia, concluding that the term 'subversive subservience' best describes the very messages

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<sup>187</sup> The most thorough history of Lovedale came from one of its Principals, written in honour of its centennial; Robert H.W. Shepherd, *Lovedale South Africa: The Story of a Century 1841-1941* (Lovedale: The Lovedale Press, 1940). Shepherd also wrote a more condensed piece on the Institution, focussing on eras of its Principals; *Lovedale South Africa: 1824-1955* (Lovedale: The Lovedale Press, 1971). Another work, whose title demonstrates its hagiographic portrayal of the mission, as much as its opinion of South African society, nevertheless contains, at points, important information: Robert Young, *African Wastes Reclaimed: Illustrated in the Story of the Lovedale Mission* (London: J.M. Dent, 1902). Adrian Hastings, in an article on the nexus of Christianity and liberation movements (in mid-20<sup>th</sup> century history) highlighted the role of Lovedale as a place of liberal thought and political voice; Hastings, 'The Christian Churches and Liberation Movements in Southern Africa', *African Affairs* 80, no. 320 (July 1981): 345.

<sup>188</sup> R. Hunt Davis, 'School vs. Blanket and Settler: Elijah Makiwane and the Leadership of the Cape School Community', *African Affairs* 78, no. 310 (January 1979): 12-31.



and work they were producing in response to the mission's teaching.<sup>189</sup> More recently, T. Jack Thompson has highlighted the role that Lovedale played in empowering black evangelists to the interior of Africa during this same period, bringing to light the important aspect of the central role Africans themselves have played in the Christianisation of Africa.<sup>190</sup>

While these are clearly important works, an area that has largely been ignored is a scholarly examination of the medical work of Lovedale, which this thesis seeks to address. But before moving into the main focus of this work, which centres on Dr Neil Macvicar and the Victoria Hospital, it is important to examine and analyse the 19<sup>th</sup> century medical mission of Lovedale.

The seeds of Lovedale, and Scottish Presbyterian missionary activity in this realm, can be traced back to the late 18<sup>th</sup> century. Scots were down in the Cape area of South Africa as part of the British armed forces from 1795 – 1803 and again from 1806, as the United Kingdom asserted control over the region, replacing Dutch rule. The British government, however, did not provide Presbyterian chaplains for Scottish soldiers (who were largely Presbyterian), thus causing some of the men to begin meeting and founding what they called 'The Calvinist Society'. It was at this time that the Rev George Thom, a Presbyterian minister with the London Missionary Society on layover in the Cape before his planned departure for India, began more formal ministry to his fellow Scots. The provisional nature of this work, however, turned into a long-term commitment and Thom consequently started a Presbyterian

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<sup>189</sup> Leon de Kock, *Civilising Barbarians: Missionary Narrative and African Textual Response in Nineteenth-Century South Africa* (Johannesburg: Witwatersrand University Press, 1996).

<sup>190</sup> T. Jack Thompson, *Touching the Heart: Xhosa Missionaries to Malawi, 1876-1888* (Pretoria: University of South Africa Press, 2000).

church in Cape Town in 1813 (while still maintaining links with the LMS). It was this same Rev Thom who eventually played an important advisory role in the Glasgow Missionary Society's decision to begin work in 'Kaffraria' (eastern portion of Cape Colony), which in turn led to the establishment of the Lovedale mission.<sup>191</sup>

The Glasgow Missionary Society was begun in 1796 with great zeal amongst the small number of its evangelically minded leadership, but from 1801-1820 failed to send out any missionaries. By April of 1821, William Ritchie Thomson and John Bennie left Scotland to begin mission work within South Africa. Settling into work at the 'Chumie' station, working with Rev John Brownlee, who was formerly working with the London Missionary Society, but had been contracted as a missionary under governmental pay.<sup>192</sup> A few years later, Bennie and a new missionary from the Glasgow Society, Rev John Ross, set off to begin a new mission station, known as 'Incehra', located 12 miles from Chumie, on the Incehra River. A year later, in December of 1825, they wrote home to the Glasgow Missionary Society, to inform them that they were changing the name of the mission to 'Lovedale', after the late Rev John Love, the long serving leader of the Society.

In the 1834-35 war between the British and the Xhosa, the Lovedale mission burned down and the site was consequently moved to its permanent location on the Tyumie River. This period saw much expansion, both in terms of missionary presence as well as in African response to the missionaries. With further mission stations established in the region – Burnshill and Pirie – as well as the erection of

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<sup>191</sup> Robert Whyte, *St. Andrew's Presbyterian Church, Cape Town: A Centenary Record*, (Cape Town: Presbyterian Bookroom, 1929), 7-10.

<sup>192</sup> Shepherd, *Lovedale South Africa 1841-1941*, 23-33.

churches and schools, establishment of a printing press, and eventually a seminary. It was this goal of training up well educated black and white teachers, evangelists, and catechists, which prompted the establishment of the Lovedale Institution in 1841, under the direction of William Govan, who led the school for thirty years.<sup>193</sup> One of the most notable changes for the mission occurred early in Govan's tenure. After the establishment of the Free Church of Scotland, in the Great Disruption of 1843, the missionary work and stations of the Glasgow Missionary Society wholly transferred to the Free Church, both in Africa as well as India. From 1844, Lovedale was thereafter under the auspices of the Free Church of Scotland Foreign Mission.

### ***The Early Medical Work at Lovedale***

#### **James Stewart**

In an address to the General Missionary Conference held in London in October 1878, the Rev Dr James Stewart, who had trained as a medical doctor, outlined the central aims of Lovedale. Beyond the four most important facets of the mission – the training of preachers, teachers, artisans (“of civilised life”, such as wagon-builders, blacksmiths, bookbinders, and agriculturalists), and general education – any aspect of health education, let alone training in medical sciences or the wide provision of medical services, was entirely absent.<sup>194</sup> Indeed, earlier that year, in the beginning of an article first read at a missions conference in Shanghai, on medical missionary work in China, an editor of *The Christian Express*<sup>195</sup> began the

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<sup>193</sup> Shepherd, *Lovedale South Africa 1824-1955*, 5-15.

<sup>194</sup> James Stewart, ‘Lovedale, South Africa’, in *African Papers*, compiled by James Stewart (n.d., n.p [c. 1882]), 5-7.

<sup>195</sup> This could possibly have been Stewart himself, as he was often heavily involved with the missionary journal published at Lovedale, but it could not be ascribed to him with any certainty.

article with the brief introduction: “Very little has been done in Africa as yet by the agency of Medical Missions.”<sup>196</sup> For both Lovedale as well as other mission locations in the continent, this was certainly a true statement.

Nevertheless, by the time of his Duff Missionary Lectures of 1902, Stewart was able to remark, “For a long time more or less medical assistance has been given at Lovedale to the natives of the district.”<sup>197</sup> His comment regarding the ‘more or less’ aspect of medical attention at the mission is especially apt given the ups and downs of obtaining and retaining trained medical personnel at the mission in addition to Stewart himself. In point of fact, medical work had never been emphasised at the mission, owing to a number of factors, primarily high costs and limited personnel, though a lack of strong desire might also be mentioned. Over the course of Stewart’s many years at the station in the latter portion of the 19<sup>th</sup> century, he himself was the primary medical practitioner.

James Stewart first came to the attention of many in Scotland after his exploratory travels up the Zambezi, part of which were in conjunction with David Livingstone. Stewart had sailed from Glasgow to South Africa with Mrs. Livingstone in the summer of 1861 and it was probably due to her insistence that he travel overland within South Africa with her which put him in better stead to travel with Livingstone.<sup>198</sup> By early 1862 they met up with the famous explorer and

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<sup>196</sup> ‘Medical Missions’, *CE* January 1878, 5.

<sup>197</sup> James Stewart, *Dawn in the Dark Continent* (New York: Young People’s Missionary Movement, [1903]), 192.

<sup>198</sup> James Wells, *The Life of James Stewart* (London: Hodder and Stoughton, 1909), 43, 54-55.

Stewart travelled, for a while, with Livingstone's party, assessing the feasibility of beginning Presbyterian missionary activity in the Central African interior, a strongly held desire. After having been away from Scotland for nearly two and a half years, Stewart returned home and resumed his medical education. Prior to his departure for Africa, Stewart had begun medical studies in Edinburgh. Upon returning he took them up again, though this time in Glasgow, working, at one point, as a dresser under the famous surgeon, Joseph Lister, at the Royal Infirmary. By August 1866 Stewart was a fully qualified medical doctor, while also having been ordained a missionary of the Free Church Presbytery of Glasgow a year and a half earlier (he had already been licensed a preacher by the Free Church upon completion of his theological studies in 1860).<sup>199</sup>

In January of 1867 Stewart arrived at Lovedale with his wife, Mina, and another woman who was to prove important in medical work at Lovedale, in addition to Livingstonia and Cape Town, in later years: Miss Jane Waterston. Up to the point of Waterston's return, as a medical doctor, several years later, however, Stewart was the only qualified medical practitioner on the Lovedale staff and it was he who tended the varying problems of ill health. Yet with all of the responsibilities tied to him at Lovedale as well as his involvement in other arenas,<sup>200</sup> medical work, and medical missionary work most especially, was marginalised and largely confined to

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<sup>199</sup> Shepherd, *Lovedale South Africa, The Story of a Century*, 170.

<sup>200</sup> During the last few decades of the 19<sup>th</sup> century, Stewart was actively involved in the founding of Blythwood, Livingstonia, and the East African Mission, just to name a few of the enterprises that occupied his time and talent, in addition to the Principalship, other duties at Lovedale, and various educative and missionary work within South Africa.

caring for the people of Lovedale – missionaries and students alike.<sup>201</sup> At times, when the district doctor of Alice was away, Stewart was called upon to provide medical assistance to those in the surrounding region, but this seems to have been, for the most part, the extent of Lovedale’s medical work interacting with the wider community; and this nearly altogether excluded the larger African population.<sup>202</sup> By January 1880, Stewart was writing back to Scotland quietly recommending that Waterston begin medical work at Lovedale.<sup>203</sup> It was unbeknownst to him that Dr Waterston, by this time a fully qualified medical doctor, was encountering a hard time in her work at the Livingstonia mission in what was then referred to as British Central Africa (modern day Malawi).

## **Jane Waterston**

### *Lovedale*

When Jane Waterston returned to Lovedale in the spring of 1880 as a fully qualified (though not recognised) medical missionary the reality of a greatly expanded medical missionary presence at the mission seemed to be taking shape. In reality, however, this optimistic surge was short lived and Waterston left the mission for private practice just a few years later. As already remarked, Waterston had first

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<sup>201</sup> “Jubilee of the Victoria Hospital Lovedale”, *CE* 2 April 1948, 124. Wells shares the rather outstanding story of Stewart travelling 150 miles to attend an ill African woman (Wells, *James Stewart*, 225). However, in the way he writes of this, I think he misconstrues an earlier story told by Young in *African Wastes Reclaimed*, 185. Though Stewart journeyed several times to see the young woman, in point of fact, she lived ten miles away from Lovedale. It is, nevertheless, a worthy example of medical missionary devotion on Stewart’s part.

<sup>202</sup> Wells, *James Stewart*, 94-100, 222-230.

<sup>203</sup> James Stewart, Lovedale, to Mrs Eliza Stephen, Scotland, 27 January 1880, in *The Letters of Jane Elizabeth Waterston*, 172 [*LJEW*, hereafter]. The Stephens, especially Eliza’s husband, John, were the couple who really became the financial backbone of medical work at Lovedale, as seen in the case of Dr Waterston, discussed below, and years later with Dr Neil Macvicar’s salary upon arrival (discussed in chapter 4).

joined Lovedale in 1867, arriving with Stewart and his wife. She had left Scotland to become the head of the new Lovedale Girls' School, which eventually opened in August of 1868. In words oft-cited by historians, Waterston commented on her overarching goal not simply related to the Girls' Institution but as a broad goal in her missionary goal:

The aim with which I started was not to turn out school-girls but *women*, and with that aim in view I tried to give the Institution not so much the air of a school as of a pleasant home. I reasoned after this manner, that *homes* are what are wanted in Kafirland, and that the young women will never be able to make homes unless they understand and see what a home is.<sup>204</sup>

Such efforts at 'civilising' or 'domesticating' the young women were a common – sometimes implicitly, though often explicitly – aspect of many missionary endeavours, and the transference of Western norms, at this time.<sup>205</sup> But Waterston's service as Superintendent of the Girls' Institution ended after six years. She resigned in the spring of 1873 and left Lovedale in January 1874 at which time she began working, in what might be called a kind of internship, at Somerset Hospital in Cape Town.

#### *Medical Education*

Bean and van Heyningen have remarked that the thought of medical work may have been lying dormant for a few years in Waterston's mind, but this does not

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<sup>204</sup> Jane Waterston, quoted in *African Wastes Reclaimed*, 132 [emphasis hers].

<sup>205</sup> For an insightful discussion on one of the most common ways of relating the 'civilising' aspects of the mission endeavours – through the means of missionary photography see: T. Jack Thompson, *Capturing the Image: African Missionary Photography as Enslavement and Liberation*, (New Haven: Yale Divinity School Library, 2007).

Jacklyn Cook has provided the insightful comment on Waterston's training of women for certain aspects of domestic married life, while she herself rejected this lifestyle. See, Cook, 'What is Progressive Feminism?' Questions Raised by the Life of Jane Waterston (1843-1932)', *Agenda* no. 5 (1989): 9.

reveal itself with any certainty until she prepared to leave Lovedale.<sup>206</sup> In a letter to Stewart shortly after commencing her hospital work in Cape Town she described assisting the dresser and at least one operation she observed first hand – all of it work that she was greatly enjoying.<sup>207</sup> In March of that year she sailed back to Scotland to see her family and commence studies for a medical degree. As a woman, however, there was no longer a possibility of becoming a fully recognised medical doctor due to a recent court decision; this did not, however, preclude Waterston from wondering about further medical education.<sup>208</sup> By September of 1874 she tentatively planned to commence studies at the newly established London School of Medicine for Women.<sup>209</sup> While her letters to Stewart during this period reveal her unguarded (and often very entertaining) attitude toward various personalities in medicine, mission, and science – “I cannot bear Jex Blake.<sup>210</sup> Nature certainly made a mistake in making her a woman. She wants to make friends with me and I am keeping her at arm’s length... Jex is not a first rate student, that I can see...”, “...I am sick of Tyndale and Darwin, the ape-faced man.”, “Though I got to like Dalzell better in Natal, still my opinion of him has never changed... He is a *coward*, headstrong, and

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<sup>206</sup> *LJEW*, 44.

<sup>207</sup> Jane Waterston, Cape Town, to James Stewart, Lovedale, 15 January 1874, in *LJEW*, 46-47.

<sup>208</sup> Jane Waterston, Inverness, to James Stewart, 13 July 1874, 20 August 1874, in *LJEW*, 62-63, 73.

<sup>209</sup> This creation of this School was largely due to the work of such women as Elizabeth Garrett-Anderson. See, E. Moberly Bell, *Storming the Citadel* (London: Constable & Co, 1963), 46-61, 84-110.

<sup>210</sup> Sophia Jex-Blake, who also played a central role in establishing the School after a noble, yet notable, failure in gaining medical education for women in Edinburgh. For a thorough biography, see Shirley Roberts, *Sophia Jex-Blake* (London: Routledge, 1993); Bell, *Storming the Citadel*, 62-83. In Roberts’ work, note that Jane Waterston would more accurately be described as a Scotswoman (not a South African), and that her work as a medical missionary was not mentioned (though it is for Fanny Butler, who went out as the first British medical missionary with the CMS to India), although her work within South Africa is noted, 149.



he is coarse at the core.”<sup>211</sup> – they also, quite importantly, disclose her understandings not only of medical work, but thoughts regarding pioneering mission work.

In her opinion, for instance, missionary labour in a new setting was of utmost importance and should not be done rashly, but with slow and unexciting patience, all while observing such Victorian Scottish Presbyterian norms as not working on Sundays.<sup>212</sup> This seems to have been at odds with others who she thought were either naïve or saw the end goal of missionary/civilising work as more important than the means of how such work was accomplished. Or take, for example, her statement,

Do you know that from the bottom of my soul I believe there is more hope for the Central African savage than for those of the slums of London.... I come home sometimes sick at heart from an afternoon in the outpatient room [at her inner city medical work]. The sin and brutality sometimes, nay rather often, brought to light there is simply appalling...<sup>213</sup>

Without attempting to draw too much out of one statement, it is noteworthy to see how she classifies ‘the African’ with the British lower class.<sup>214</sup> Additionally, Waterston saw great hope in her perception of the ‘savage African’ as a type of blank slate – just waiting for the ‘more civilised’ European to come and ‘help them up the civilisation ladder’ – whereas the British lower class, in her view, had perhaps squandered their opportunity, or gone beyond the range of help due to the harsh conditions of urban life. Such insights provide a more nuanced understanding of missionary motivations and understandings of the people they thought they were to

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<sup>211</sup> Jane Waterston, London, to James Stewart, 30 October 1874, 8 December 1874, 30 January 1875, in *LJEW*, 77-81.

<sup>212</sup> Jane Waterston, London, to James Stewart, 30 January 1875, 14 May 1876, in *LJEW*, 82, 98.

<sup>213</sup> *Ibid.*, 98.

<sup>214</sup> For another striking example with this transference or comparison, see Waterston, London, to James Stewart, 23 October 1876, in *LJEW*, 104.

encounter. It furthermore demonstrates an apt example of typical middle class attitudes toward 'other' groups, an important consideration during medical missionary history during this period.

Upon completing her studies at the London School of Medicine for Women as well the practical training in both London and Dublin, she received her licentiate from the King's and Queen's College of Physicians of Ireland, upon passing the appropriate examinations. Waterston was adamant about going out to the Livingstonia Mission in Malawi as a medical missionary with the Free Church of Scotland mission. However, as the Free Church claimed that there would not be enough medical work, she expressed a willingness to undertake other mission work – so long as it was subordinate to her medical practice (which she nevertheless expected to perform every day).<sup>215</sup> Appointed in December 1878 to the Livingstonia Mission, as a 'female assistant' and not a 'medical missionary', Waterston was the first British female missionary doctor to Sub-Saharan Africa, certainly in Central Africa.<sup>216</sup> Yet Waterston was sent out under stipulations which placed both her and her professional status in a subordinate role to the younger doctor (Robert Laws), as well as with medical work secondary to pedagogical.<sup>217</sup> Under these conditions,

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<sup>215</sup> She explicitly expressed these qualifications to Stewart who was meeting with members of the FCS FMC to decide her appointment, Jane Waterston, London, to Stewart, 3 July 1878, in *LJEW*, 116-118.

<sup>216</sup> Thompson, *Touching the Heart*, 51-52.

<sup>217</sup> Note Markku Hokkanen's insightful commentary on the power relations between Waterston and Laws or Waterston and the mission authorities in Scotland when she was actually out in the field. Laws, for instance, was always referred to as 'Dr Laws', while Waterston, a fully qualified medical doctor, was 'Miss Waterston'. Markku Hokkanen, *Quests for Health in Colonial Society* (Jyväskylä, Finland: University of Jyväskylä, 2006), 131-134.

Waterston sailed in June of 1879, and once ashore in South Africa, she set off for Livingstonia, stopping at Lovedale along the way.<sup>218</sup>

#### *Livingstonia*

While at Livingstonia, one of Waterston's responsibilities involved caring for those engaged in the mission – as touched upon in chapter 1, this was a common aspect of medical mission work. Yet her main work was with the people of the area, and the number of patients seems to have picked up shortly after her arrival, just as it had when she was briefly at Blantyre.<sup>219</sup> While she did not actively go out seeking opportunities to undertake medical work, word of her seemed to spread rather quickly; perhaps a Western medicine woman was of particular interest for the local population. In line with her determined personality, and akin to the later practice of the Universities' Mission to Central Africa, Waterston was not hesitant to pay visits to outlying areas, which she sometimes accessed by boat.<sup>220</sup>

In terms of actual medical work, the doctor encountered both classic as well as atypical ailments during her time in central Africa. Fever was overwhelmingly the most common illness, while dysentery was also a rather common complaint. Another typical illness, in certain areas, was malarial fever and its associated ailments. Waterston related one case of severe fever which struck the engineer of the

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<sup>218</sup> Rennick, *Church and Medicine*, 188-189.

<sup>219</sup> Jane Waterston, Blantyre, to James Stewart, 31 October 1879, in *LJEW*, 159. On the way to the Livingstonia Mission, Waterston stopped at the Church of Scotland Blantyre Mission in Malawi, staying just a short time.

<sup>220</sup> Jane Waterston, Livingstonia, to James Stewart, 29 December 1879, in *LJEW*, 162-166. For the UMCA work, see the extensive work: Charles M. Good, Jr., *The Steamer Parish* (Chicago: The University of Chicago Press, 2004).

*Lady Nyasa* while they were still working their way up the Shire River. The man, at her instruction, was treated with rest, varied meals, fellowship (he was made to eat with them), coffee and quinine; and due to his recovery, perhaps largely owed to quinine, he was likely sick with malaria.<sup>221</sup> Rather intriguingly, Waterston wrote of the possible presence of Yellow Fever at Quelimane (a seaport in modern day Mozambique, then often referred to as Quillimane) at the beginning of September 1879, early in their river travel. In a clear demonstration of her exacting mind, a valuable skill in such pioneer medical work, she investigated the recent deaths and was divided in her final judgment about its presence; the symptoms had likenesses to that of Yellow Fever and the disease had been in Lisbon recently, but she also found that the men who had fallen ill had been very heavy drinkers (something she believed “had thoroughly poisoned their blood”) and she could not ascertain whether a ship had recently been in port in Portugal. Her final medical opinion regarding its presence was inconclusive, but her practical reasoning was most sensible: “We are well out of here quickly.”<sup>222</sup> A last incident worth mention occurred when she travelled about 200 miles (on foot, at least part of the way) to tend to an Englishman who had been badly burned – Herbert Rhodes, the elder brother of Cecil Rhodes. As it turned out, however, he had already died by the time she got there.<sup>223</sup> This incident demonstrates very well her firm resolve as a doctor (whose chief aim is to heal, if

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<sup>221</sup> Jane Waterston, Katunga’s Place, River Shire, to James Stewart, 4 October 1879, in *LJEW*, 154.

<sup>222</sup> Jane Waterston, Quillimane, to James Stewart, 12 October 1879, in *LJEW*, 152. This particular episode of Waterston’s investigation is a striking example of epidemiological detection in its day, relying upon observation, etc., as opposed to bacteriological work in a laboratory (which would not have been available anyway). I am indebted to insights in this area provided by Professor Anne Hardy, of the Wellcome Trust Centre for the History of Medicine at University College of London, at her seminar, ‘History of Epidemiology: The Science of Detection, 1890-1960’, given at the Royal College of Physicians, Edinburgh, 13 February 2008.

<sup>223</sup> John Lennox, ‘Dr. Jane Waterston’, *SAO* December 1932, 232.

possible), and further illustrates an example made in chapter 1 regarding the role of medical missionaries caring for fellow Westerners in isolated regions.

Her other medical work included minor surgical procedures as well as the treatment of boils, cuts, etc. Waterston also pointed to hygiene issues around the Livingstonia mission, especially related to water quality and waste management. Though the mosquito-malarial link was not seen as scientifically verifiable at this time, standing water was problematic in any number of ways and perhaps not least in becoming a breeding ground for mosquitoes, let alone diseases such as dysentery. That season had been a wet one and Waterston's opinion was that stagnant pools, improper drainage attempts (if at all), as well as inadequate means of human waste disposal, were leading to a very unhealthy environment for the people living in the area. Her calls for action to improve public health were, according to her, were not heeded, and undoubtedly led to her increasingly low opinion of Livingstonia mission policies.<sup>224</sup> As such, it is a marked example of Laws' stubborn attitude toward the new female medical authority, though he would not have been alone in his assessment of the situation, given much of Britain's small (though growing) concern for public health measures and disease control during this time.<sup>225</sup>

One last comment regarding medical treatment may be noted here. In caring for the dying George Benzie, captain of the *Ilala*, Waterston exposed another significant attribute of first-rate doctoring, which was especially valuable in such removed environs – the study, adaptation, retention, and dissemination of effective treatment knowledge for particular cases. Though Benzie passed away,

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<sup>224</sup> Jane Waterston, Livingstonia, to James Stewart, 14 February 1880, in *LJEW*, 166.

One thing I have learnt is that a bad case here must have free stimulation at a very early date, and that eggs and milk can and ought to be administered. They were relished and got down more easily than anything else, far better than soup, and beaten up with brandy as I learnt to do in Hospital, made splendid stuff and occasioned no bad symptoms. In fact my only regret is they were not given sooner. But I will tell you all when I see you.<sup>226</sup>

In relaying such information to Dr James Stewart, fellow medical doctor and influential man, what would have been seen as valuable medical treatment data was potentially carried forward to a wider circle. Such statements and medical recommendations in frontier locales demonstrate an important aspect of mission medicine: the dissemination of medical knowledge, especially emerging knowledge, and treatment, which in turn had the potential to become practised norms in future periods.

#### *The End of Livingstonia*

Within months of actual arrival at Livingstonia, a physical location she did not dislike, Waterston tendered her resignation and left by April of 1880. At a very early point within her Central African experience, the first female medical missionary in the Scottish foreign mission field was ready to terminate her work. She plainly wrote to her good friend, Dr Stewart:

If possible, recall me, for it will save me writing to the Committee and stating that the Humbug I have seen has altered my views on many subjects, that I cannot give any religious teachings as I don't know myself what I believe and that, ever since I came on the Zambezi, I have been ashamed of being a Missionary. I might manage to recover a little moral and mental tone at Lovedale, never in this country.<sup>227</sup>

Just a few weeks later she expanded on her situation:

Honestly, I don't see how I am to work here as we won't pull the same way. The girls are a bad lot and this alphabet teaching could be done by a girl at £50 a year. I like the country and I don't mind the climate, but I don't like the policy of the

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<sup>225</sup> Joan Lane, *A Social History of Medicine* (London & New York: Routledge, 2001), 134-150.

<sup>226</sup> Jane Waterston, Livingstonia, to James Stewart, 14 February 1880, in *LJEW*, 167.

<sup>227</sup> Jane Waterston, Livingstonia, to James Stewart, 11 December 1879, in *LJEW*, 162.

Mission and I fear the future. Besides, religiously my mind is in a state of confusion. I can't believe this is the Gospel. I told your cousin it was terrible pain to me to find the thing I had looked forward to and worked for turn out a very apple of Sodom. I am working hard and doing my best but I can never agree with this state of things unless all that is good in me dies. All this medical work is rousing me and I am so thankful for my profession. I am quite well, to the wonder of myself and the other people.<sup>228</sup>

This was a sharp rebuke of the new mission, and all the more bitter as she had long wanted to undertake medical missionary work in Central Africa. Waterston was understandably deeply disappointed and upset over the situation she found herself in. Though a seasoned missionary who had worked at one of the premier institutions in Africa (Lovedale), her counsel was not sought regarding the young mission (Livingstonia); although she was qualified and had been asked to teach Anatomy at the Women's Medical College in London, at Livingstonia she was assigned the duty of teaching the forty youngest pupils; while she was a fully qualified medical doctor, her counsel regarding important health issues was ignored and she was furthermore saddled with work that took her away from this unique medical skill in a pioneer setting. Added to all of this was her utter shock and horror of the way in which some of the Scottish missionaries connected with Blantyre (a Church of Scotland mission located close to Livingstonia) had conducted 'missionary' activity and treated some of the Africans.<sup>229</sup>

In the end, she concluded that she did not have the same aims as Dr Laws, the patriarch of Livingstonia, and others at the mission and consequently resigned. In a very exposed (and perhaps melodramatic) disclosure of her thoughts about her work as a female medical missionary in Africa, Waterston reveals her stubborn aims,

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<sup>228</sup> Jane Waterston, Livingstonia, to James Stewart, 29 December 1879, in *LJEW*, 166.

<sup>229</sup> For more on this dark portion of Blantyre's history, including the beating to death of a 'criminal', see Andrew C. Ross, *Blantyre Mission and the Making of Modern Malawi*, (Blantyre, Malawi: Christian Literature Association in Malawi, 1996), 18-23.

uncertain future, and theological quandaries. In this setting, it is especially noteworthy for the emphasis she placed upon the medical work in a mission setting and how she believed this ought to operate:

To be a Doctor and grapple with bad cases one must make it the first thing and read and practise or else you will run the risk of failing with a bad case and the horrible feeling that it is due to your own not being up to the mark. My medical knowledge has proved of great value to other people since I came out and I am going to stick to it. Besides, it is what I have to earn my bread with and I am fond of it. It is all I have to fall back upon if invalidated Home from here and I will not give it up for the wretched work offered me. If I don't go to Lovedale I have to pay a heavy fine to the Committee and will land in London with shattered faith, very probably impaired health, and empty pocket, such being the price of nearly a year's Missionary work in Central Africa. If I were a man I would add anything but a soft expression here. It is the shattered faith in God and Missionary work that I feel most of all. Life is no longer what it was to me and never will be again. If I come to Lovedale you will want me to conduct worship and turn up at Church and services and I can't do that at present. What I want is to be let alone and left to fight out doubts, if that be possible, and get back, not some fragments of the old belief, that is not possible, but some standing ground on which to work in the present and have some slight hope for the future. I will not sham what I don't believe for any consideration. I have got a horror of religious humbug that will last me the rest of my days. I just hate being up here.... My coming here has at any rate taught me to hate humbug and I will not risk other people's lives and my own by doing my medical work in any other fashion but as honestly and earnestly as I can, giving it the principal place in my day's work... the men say that more patients have come here since I came than ever before and my medical work has been heavy enough lately in all conscience, so much fever among the natives and if I am trying to prevent a little child sinking into that horrible coma, I can't at the same time teach A.B.C. The child is recovering but is very thin and shaky. It has been the worst case of fever I have seen among natives. I have had some desperate cases of bronchitis, too, and more surgical cases at present. I never stop now in the middle of the day. It has made me acquainted with the natives very rapidly and the Donna is somebody to them. I talk a smattering of Manyanja which I have picked up from being so much among the natives, more than from Dr Laws' lessons.<sup>230</sup>

As an independently minded woman, experienced missionary, and medical doctor, Jane Waterston provides one of the most unique outlooks on pioneer medical mission work in the whole of Africa during this period of the 19<sup>th</sup> century.<sup>231</sup> Her

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<sup>230</sup> Jane Waterston, Livingstonia, to James Stewart, 14 February 1880, in *LJEW*, 169-170.

<sup>231</sup> Elizabeth van Heyningen has utilized Waterston as an outstanding example as a minority medical practitioner in Cape Town, along with the Muslim South African doctor, Abdullah Abdurahman. See, van Heyningen, 'Regularly Licensed and Properly Educated Practitioners': Professionalisation 1860-1910', in *The Cape Doctor in the Nineteenth Century*, ed. by Harriet Deacon, Howard Phillips, and Elizabeth van Heyningen (Amsterdam: Rodopi, 2004), 214-217.



comments from this letter relate important opinions on some aspects of the role of medical missionaries, whether related to gender, missionary and Home Committee relations, inter-missions relations, or medical work. As a single female worker who felt she could no longer count on financial support from her father, Waterston's ambition to stay engaged in the medical work at the mission was deeper than just the commitment to trying to heal ill Africans or fellow missionaries – she believed it was essential for her future security.

She also expresses a significant opinion on the role and work of medical missionaries in the field: that it ought to be overwhelmingly, if not exclusively, about medical work. This very subject was, and continued to be, a source of tension and disagreement in missions, both personally and institutionally, throughout the 19<sup>th</sup> and into the 20<sup>th</sup> centuries.<sup>232</sup> And mention might also be made regarding the honest strain Waterston expressed about changed spiritual beliefs. This had the potential to disrupt future plans in missionary work, either through self-imposition or external pressures, as it had with others.<sup>233</sup>

*Lovedale*

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<sup>232</sup> It should be mentioned, of course, that many male medical missionaries in the 19<sup>th</sup> century were also ordained, thereby potentially complicating the tensions between clerical and medical responsibilities. See chapter 1 for more on this subject.

<sup>233</sup> For example, the case of Dr Hope Trant, an Irish freelance medical doctor who undertook temporary assignments throughout southern and eastern Africa during the two middle quarters of the 20<sup>th</sup> century. She performed a number of *locum tenentes* for medical missionaries in various societies, but was rejected from a permanent application for medical missionary service with a London society for religious beliefs that, “might have a disrupting influence on [her] colleagues at a mission station.” Hope Trant, *Not Merrion Square* (East London: The Thornhill Press, 1970), 48. See also chapter 3 and the discussion surrounding Neil Macvicar. It seems reasonable to conclude that Waterston's episode paved the way years later for Stewart's strong desire to attain Macvicar, ‘problematic’ religious beliefs and all.

Nonetheless, by April of 1880, Stewart was petitioning the Foreign Mission Committee to post Waterston to Lovedale explaining that medical work was sorely needed amongst the Africans and would be a great boon to their overall missionary presence.<sup>234</sup>

The following month Dr Jane Waterston arrived back at Lovedale, ready and anxious to be settled there as a medical missionary.<sup>235</sup> The Foreign Mission Committee of the Free Church, however, did not have either the same interest or timeline. By the summer of that same year, John Stephen, of Glasgow, the generous financial backer of medical work at Lovedale and one of the largest financiers of Scottish missions, began receiving updates from Stewart on Waterston, the newly established dispensary, and other issues surrounding the invigorated health-care presence. By early 1881 Stephen had personally given £240 toward the Lovedale medical work, thereby indirectly underwriting Waterston's mission salary and work among the Africans (she treated 'Europeans' in the area for additional income – medical work that she was so good at that Stewart feared she might seriously cut in to the district surgeon's wages).<sup>236</sup> One of the most intriguing ideas during this period appears in letters from Stewart. In them, he mentions how he would like to establish a college at Lovedale at which they would be able to teach medicine and

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<sup>234</sup> James Stewart, Lovedale, to Colonel Young, Scotland, 20 April 1880, in *LJEW*, 173.

<sup>235</sup> In a tribute to her after her death, the Rev. John Lennox glossed over the deeper reasons of her departure from Livingstonia, attributing it only to "ill health"; 'Dr. Jane Waterston', *SAO* December 1932, 232.

<sup>236</sup> There is a slight difference in terminology regarding her position at Lovedale during this period of medical work; though listed as 'Institution Staff' in information taken from Lovedale Reports, ('Lovedale Missionary Institution Staff from 1872 – 1899', Lovedale Box, AMKWT, p. 2), she was also described as, "not formally connected with the mission staff" in a Lovedale Report shortly after she left, *CE* January 1884, 3. I believe it was a matter of semantics, probably to keep various parties (i.e. the Foreign Mission Committee, the local district doctor) from objecting or problematising matters. The fact remains that she was central to Lovedale's medical missionary work.

confer medical degrees. While only a dream at that point, it was no small feat, seeing as how the Foreign Mission Committee had made it clear they were not interested in even the most basic medical missionary presence, by deciding not to appoint Waterston to Lovedale and demanding repayment for her salary and passage down to Africa from Great Britain.<sup>237</sup> As Waterston was part of the pioneering class of female doctors from the United Kingdom, there is little wonder at her enthusiasm to begin new medical training courses at Lovedale, especially in light of the then growing medical education, both by or for women, in other missionary arenas, such as India, China, and Burma.<sup>238</sup>

Stephen, who was a very significant benefactor to the mission, financially and otherwise, sought to enhance the medical mission presence at Lovedale. In a very revealing letter to Stewart at this same time, he disclosed a tentative offer to the cause: a one thousand pound annual gift, to be renewed over several years, a remarkable amount of money for that time.<sup>239</sup> His plan included the provision of scholarships for a few of the brightest and most clever students of Lovedale to study at the Cape College; plans to enlarge the dispensary (then the only medical facility at Lovedale); build a hospital; employ a couple of doctors (presumably Scottish medical missionaries); and finally, train up a number of young people from Lovedale in health care (probably as medical assistants, or perhaps nurses). He was also quite

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<sup>237</sup> See James Stewart, Lovedale, to John Stephen, Glasgow, 29 June 1880, 6 July 1880, 17 August 1880, 7 September 1880, 20 March 1881, as well as the informative commentary by the editors, in *LJEW*, 174-177. Young also places blame over the lack of a devoted medical presence at Lovedale squarely with the Foreign Mission Committee back in Scotland, *African Wastes Reclaimed*, 186-187.

<sup>238</sup> 'Female Medical Work', *Helping Hand*, quoted in *CE* January 1886, 12; Hardiman, 'Introduction', *Healing Bodies, Saving Souls*, 31.

<sup>239</sup> For the sake of comparison, the South African Colonial government, some twenty years later, provided two separate matching fund grants totalling £2,000 toward the Victoria Hospital. See Chapter 5 below for more on Victoria Hospital.

open to Dr Waterston being involved in this scheme, though he seemed aware that she might not be interested.<sup>240</sup> Yet, in the end, Stephen's generous offer was either rebuffed<sup>241</sup> or unable to be carried according to his parameters.<sup>242</sup>

And within a few years, Stewart seemed to lose his initial hopefulness in establishing a stronger medical scheme at Lovedale. In an address to other missionaries in South Africa, he expressed his belief that while training African men in Western medical practice was desirable, he felt that, on the whole there were not enough students of high "mental capacity", "moral trustworthiness", and a "very fine sense of duty" to consider opening a school: "It would be a hard thing to say that such Native Young Men cannot be found, but it is safe to say they do not exist in any very considerable numbers among those who belong to the class of so-called educated Young Men."<sup>243</sup> The words evince a setback to the once expectant Stewart, and are perhaps an excuse for the inability of the mission itself to construct the

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<sup>240</sup> John Stephen, Glasgow, to James Stewart, Lovedale, 27 March 1881, in *LJEW*, 177.

<sup>241</sup> Though it does not seem that Stephen was being flippant in this discourse, it is unclear why nothing came from this offer. It seems most likely that the Foreign Mission Committee of the Free Church, for whatever reason, was opposed to the plan. See a few of Robert Young's slightly terse reports against the decisions of 'the Home Committee' on this subject in *African Wastes Reclaimed*, 185-187.

<sup>242</sup> While it is not exactly obvious what connection this may have had regarding the hospital and medical scheme discussed between the two, Stewart noted in a photographic book of Lovedale that Mr John Stephen, Esq., of Glasgow, owned one of the houses, 'Block Drift' (which was used by one of the elder missionaries of Lovedale, Mr Bennie, son of one of the pioneer Glasgow Missionary Society missionaries, the Rev John Bennie), as well as some of the surrounding lands. I believe that this may have been purchased by Stephen, one of the most generous donors of Scottish missions, for the purpose of the medical scheme. See, James Stewart, *Lovedale Missionary Institution, South Africa*, (Lovedale, South Africa: Lovedale Mission Press, 1884), 26. Note that this book is a forerunner to the expanded piece published a decade later, which duplicated much of the material: James Stewart, *Lovedale, South Africa: Illustrated by Fifty Views from Photographs* (Edinburgh: Andrew Elliot, 1894).

<sup>243</sup> James Stewart, 'Is the Training of Natives as Medical Men Desirable?', *CE* August 1884, 117. For more on matters of education, see chapter 6.

planned scheme. Alternatively, they demonstrate a paternalistic and smug attitude toward young Africans in general, and Lovedale students in particular.

In an aspect of professional life often typical of medical missionaries in that day, Waterston split her duties between the mission concerns, members of the wider white public, and the African patients. She treated all of the students at the Institution, the Girls' School, and a few local 'Europeans'. Additionally, Waterston opened a dispensary, and began treating outpatients administering medicines. Between August and the end of December 1880, she handled over 800 out-patient appointments, while also performing home visits for patients too sick to make it to Lovedale. A patient's first visit to the dispensary cost one shilling, with each call thereafter charged sixpence. The total income generated from that period came to just over £23.<sup>244</sup> 1881 witnessed the African patient case load climb to over 3,000 (not counting any of the Lovedale students or local Europeans), many being referred to the dispensary by their employers. Some have utilised the term 'referring agents' for such people – whether employers, missionaries, Western educated Africans, etc. – noting their important role in the Western medical imperializing scheme.<sup>245</sup> In addition to dispensing medications and other out-patient work, Waterston performed minor surgeries,<sup>246</sup> and 1881 saw a gross intake of just over £102 in patient fees.<sup>247</sup> 1882 was another year of numerical growth with the figures more than doubling

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<sup>244</sup> Jane Waterston, 'Medical Department' in 'Lovedale Annual Report', *CE* January 1881, 3. Relating to fees charged, she also mentioned that no one was turned away if they couldn't pay the fee.

<sup>245</sup> Rennick, *Church and Medicine*, 221.

<sup>246</sup> Waterston sent more serious cases to hospitals, probably to places like Grey Hospital in King William's Town.

<sup>247</sup> Jane Waterston, 'Lovedale Dispensary' in 'Lovedale Annual Report', *CE* January 1882, 4.

again, culminating in over seven thousand total out-patient treatments.<sup>248</sup> Without wanting to extract too much from simple figures, there are certainly striking facets to this work. Foremost of these is that it seems Africans welcomed the opportunity for Western medical treatment, by patronizing the dispensary. While there is certainly no reason to conclude that they were adopting Western understandings of disease causation or treatment, and thereby replacing their own traditional practices, it seems that a growing number were adopting, at least in part, aspects of Western mission-based medical treatment.

*Waterston's Departure from Lovedale*

During this period, Stewart wrote to Stephen and, while not discussing any plans of initiating a Medical School, he explained in greater detail the situation regarding Waterston. Stewart expressed his very high opinion of her, personally; as a medical man himself, he termed her a “splendid doctor”, noting that she “does her work excellently”; and as the Principal of Lovedale, he believed she was “thoroughly loyal” and could be “trusted implicitly”.<sup>249</sup> Yet he also acknowledged that others did not seem to always get on very well with her. Regarding this last comment, one might potentially maintain that Waterston elicited particularly strong distaste amongst certain men, such as Robert Laws of Livingstonia or Macklin of Blantyre,<sup>250</sup> due to their sexist views regarding a strong-willed female doctor, but it must also be

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<sup>248</sup> Young, *African Wastes Reclaimed*, 186.

<sup>249</sup> James Stewart, Lovedale, to John Stephen, Glasgow, 18 September 1882, in *LJEW*, 180-182.

<sup>250</sup> Rennick, *Church and Medicine*, 188.

remembered that many women – some of them fellow doctors – simply did not take to her personality either.<sup>251</sup>

Nevertheless, by late 1883, Waterston resigned from Lovedale to begin private practice in Cape Town, where she resided for the next half century. She did well there and she became very active, not only among the Bantu-speaking populations,<sup>252</sup> but in teaching, advising,<sup>253</sup> and community involvement,<sup>254</sup> eventually becoming a well known institution in the city. With her departure, Lovedale lost an established and competent Western medical practitioner as well as any tangible hope for the immediate development of an expanded medical presence.

### **Govan Koboka**

#### *Early Training*

The only brighter aspects of any medical work at the mission during this period were short lived and, to a certain degree, serve only to highlight the lack of any fortified effort in this field. Before Waterston left Lovedale to take up private practice in Cape Town, she was assisted by an African dispenser, Mr Govan Koboka.<sup>255</sup> Having received his early education at Lovedale, and working a short

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<sup>251</sup> Deborah Gaitskell, 'Women, Health and the Development of Medical Missions: Some South African Reflections', in *Gender, Poverty and Church Involvement, A Report from a Research conference in Uppsala, May 6-8, 2002*, edited by Katherina Hallencreutz, 66-67. Found online at <http://urn.kb.se/resolve?urn=urn:nbn:se:uu:diva-5860>

<sup>252</sup> She was apparently the only white doctor in Cape Town, in those early years, who could speak more than a smattering of some southern African languages; Laidler and Gelfand, *South Africa: Its Medical History*, 341; John Lennox, 'Dr. Jane Waterston', *SAO* December 1932, 232.

<sup>253</sup> For more on her time in Cape Town, until 1905, including service on the Concentration Camps Commission, see Bean and van Heyningen, *LJEW* 246-247. Waterston also provided opinion for the 1893 Labour Commission, Laidler and Gelfand, *South Africa*, 341.

<sup>254</sup> Laidler and Gelfand, *South Africa*, 374-375.

<sup>255</sup> *Lovedale Missionary Institution Staff from 1872-1899; Taken from Reports*. Lovedale Box, AMKWT, 2. One can assume that Koboka's first name was derived from the Rev. William Govan,

time as a teacher in the Sheshegu Station School near Alice, Koboka left in 1861 to be trained in medical assistance work by Dr John Fitzgerald at the Grey Hospital in King William's Town.<sup>256</sup> Fitzgerald had been an instrumental player in the attempt by Sir George Grey, then Governor of British Kaffraria, to not simply populate the expanded borders with Europeans, but to provide Western medical service to the population – both white and black. With an aim to upending the traditional African health practitioners (popularly called 'witchdoctors' by the whites), Grey sought to build a number of 'cottage hospitals' in the newly expanded area under his authority.<sup>257</sup>

Fitzgerald, an Irishman who was trained in medicine at Glasgow, had arrived in King William's Town in 1856 as the director of the Medical Department of British Kaffraria and Superintendent of Native Hospitals,<sup>258</sup> and shortly thereafter began growing his medical practice amongst Africans, part of which was due to the effects of the great Xhosa Cattle-Killing Movement,<sup>259</sup> which witnessed a number of Africans come under his care in its aftermath. Due to a lack of medically trained

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the first Superintendent of the Lovedale Institution. Note the use of 'Kovane Koboka' in the Laidler and Gelfand (Index), p 522, which may have been drawn from recorded sources during his time at Grey Hospital. There is also the distinct possibility that 'Kovane' is what might be termed as an 'Africanising' of the name 'Govan'.

<sup>256</sup> Laidler and Gelfand, *South Africa, Its Medical History*, 296-303. Laidler and Gelfand, in endnote 21 (pg. 305), mistakenly state that Fitzgerald's *A Short History of the Native Hospital, King William's Town, British Kaffraria*, was written in 1855; the correct date should be 1864.

<sup>257</sup> Laidler and Gelfand, *South Africa, Its Medical History*, 295-297. See chapter 3 for more on the interaction between Western medicine and African traditional practitioners.

<sup>258</sup> 'Witch Doctors of South Africa' *The Lancet* 80 October 1862, 396; Laidler and Gelfand, *South Africa*, 296.

<sup>259</sup> From 1856-1857 a large number of Xhosa followed the direction of a teenage prophetess, Nongqawuse, her uncle, Mhlakaza, and paramount chief, Sarhili in killing their cattle to bring about the salvation of their land and freedom from the ever growing white encroachment. Nongqawuse was reported to have been visited by ancestors who told her that upon the extermination of the cattle, and without having planted crops, the dead would rise up to defeat the whites on 18 February 1857.



white personnel, Fitzgerald began training African assistants, including Ned Macomo and Nana Ganya, the latter of whom was reportedly well regarded in the area of tooth extraction.<sup>260</sup> In his five years under Fitzgerald's tutelage, Koboka received 'hands on' training in surgical dressing as well as in the dispensary, apparently even having passed an "examination in general knowledge required by the English College of Surgeons".<sup>261</sup> For reasons that remain unclear,<sup>262</sup> but which might be due to the quick demise of the Grey hospital, Koboka discontinued his employment there in 1866, and, in addition to other jobs, worked for a number of years as an interpreter; first in Fort Beaufort, in the Resident Magistrate's Office (1873-1876), then for a government agent, G.M. Theal, and his dealings with Chief Oba in Victoria East. By 1878 he had returned to dispensary work, this time at the Native Depot in Cape Town, before returning to Lovedale in 1879.<sup>263</sup>

Koboka spent the next couple of years working with Waterston as the Lovedale Dispenser, and it is logical to suppose that his extensive work in both fields, medical assistance and interpretation, was of great value. His Western education, skills in communication and, perhaps most importantly, the keen understanding of the patients' background and worldview, would have been an invaluable asset for the medical work at Lovedale during this period. And his appointment may go against common conceptions of strict and overly moralistic

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Though not all Xhosa followed this advice, many did, and the malnutrition and displacement which ensued was devastating for tens of thousands of Xhosa, many of whom starved to death.

<sup>260</sup> Laidler and Gelfand, *South Africa*, 296.

<sup>261</sup> *Ibid.*, 302. Note that Koboka was joined by another Lovedale alumnus, William Daniell; Laidler and Gelfand, *South Africa*, 303.

<sup>262</sup> Bean and van Heyningen, in footnote 72, write that Koboka, "had to leave under a cloud", raising the possibility of questionable allegations for his departure from Grey Hospital; *LJEW*, 38.

<sup>263</sup> *Lovedale: Past and Present*, 117-118.

mission policy, considering the possibility of ‘misconduct’ at the Grey Hospital and missionary responses which may have seen him as having possibly committed a ‘moral indiscretion’ or maintaining a ‘character flaw’ and therefore unworthy of any medical work at the mission. Indeed, Waterston had, back in 1872, explicitly mentioned him to Stewart in a letter remarking, “Don’t admit that rascal Govan. I have heard a good deal about him since you left”.<sup>264</sup>

#### *Lovedale Dispenser*

When Waterston departed in 1883, Koboka, overseen by Stewart, ran the dispensary work by himself for four years. In 1884 there were 238 ‘new patient’ and 186 ‘old patient’ visits, for a sub-total of 424 out-patient treatments, a number referring to Africans in the surrounding areas; with students from Lovedale and ‘European’ patients are included, the total jumps to 1,398.<sup>265</sup> The following year, Koboka treated 295 ‘new patients’ and 209 ‘old patients’ (504 total) from the outside community, a 19% increase.<sup>266</sup> By the end of 1886, the Lovedale dispensary had treated 354 ‘new patients’ and another 229 ‘old patients’, recording another year of numerical growth.<sup>267</sup> In his last year as the Lovedale Dispenser, Koboka had 362 ‘first visits’, and 148 ‘seconds’, totaling 510. When taken together with the total number of out-patients from the “population round Lovedale, pupils, servants, and

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<sup>264</sup> Jane Waterston, Lovedale, to James Stewart, Port Elizabeth, 29 February 1872, *LJEW*, 38.

<sup>265</sup> ‘Lovedale Dispensary’, *CE* January 1885, 14.

<sup>266</sup> ‘Lovedale Dispensary’, *CE* January 1886, 8. 1885 saw a drop in the number of out-patients from Lovedale or the white community: 1,289.

<sup>267</sup> ‘Lovedale Dispensary’, *CE* January 1887, 5. As with the previous year, the number of visits by those within the Lovedale schools or the ‘European’ community “in or around the Institution” dropped to 1,050.

others”, he administered 1,228 total treatments in 1887.<sup>268</sup> While such work was certainly respectable, the numbers clearly reveal a dramatically reduced case-load after Waterston’s departure, from over 7,000 in 1882 to fewer than 1,300 by 1887, a reduction greater than 80%.

Though it was apparently not unexpected, Koboka died in early 1888. And with his death, Lovedale’s medical presence went from poor to poorer, altogether ceasing to operate for a few years. During this period of medical work by Waterston and Koboka, from late 1880 through 1887, a total of 13,603 out-patients treatments were administered.<sup>269</sup> Though the numbers were much greater while Waterston was present (and as a fully qualified medical doctor this isn’t surprising) Koboka was reportedly exceptionally good at his job, never having been known to have made a mistake in his time at Lovedale, according to one author.<sup>270</sup> What is perhaps most striking for this period is the fact that Lovedale, seen by so many in its day as perhaps the most prestigious European mission in the whole of Sub-Saharan Africa, could not cultivate a medical missionary presence, let alone sustain what it did provide, in terms of medical expertise.<sup>271</sup> Yet the very centre of what it did provide was supplied (and supplied rather well) by those that were otherwise marginalised – a woman and a black African – by the Western system.

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<sup>268</sup> ‘Lovedale Mission Dispensary’, *CE* January 1888, 4.

<sup>269</sup> The Lovedale Dispensary report for 1886 provides the numbers for the years previous to Koboka’s charge of the Dispensary.

<sup>270</sup> Young, *African Wastes Reclaimed*, 187. Though this may be dismissed by some as a rather hagiographic portrayal (in the ability of Lovedale’s education system, if nothing else), it is nevertheless a rather outstanding praise of Koboka’s professional ability. Indeed, it runs against the common assumption held by many during this period that Africans might be trained for ‘lower skilled’ jobs, but would never truly master more technical work.

*Limited and Transitory Medical Presence*

With Govan Koboka's passing, Stewart was once again the only one handling medical responsibilities on the site. A few years later, though, the arrival of another medical doctor, as well as another African dispenser, again changed the prospect of wider medical work at Lovedale.

In September 1888 a British man-o'-war, the *Osprey*, overran Arab ships in the Red Sea carrying slaves. The vast majority of these Oromo<sup>272</sup> slaves were women and children, and after being taken to Aden, the Keith-Falconer Mission, a Free Church of Scotland enterprise, was asked by the British colonial authorities to take charge of a number of the children. Due to continued poor health, it was decided that the location was not good for the children and rather than trying to return them to their homeland, in southern Ethiopia, or keep them in southern Arabia, it was decided to send them to Lovedale to be educated. Dr. Alexander Paterson, who had been working at the Keith-Falconer station, along with a teaching colleague, led the group of over 60 children to Lovedale. Arriving at Lovedale on 22 August 1890, just a month after leaving Aden, Paterson began a short stint as the medical doctor for the mission, while also helping with the education of the Oromo children. However, this medical assistance was brief. Within a year Dr Paterson married one of the assistant teachers, Miss Muirhead, and by the middle of 1891, they left to begin mission work together, ultimately spending many years in Hebron, in

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<sup>271</sup> In 1884 a Dr Stirling, of Perth, Scotland, had visited Lovedale in hopes of helping establish a hospital, but monetary and control issues proved problematic, though the background of this remains unclear. This proved a further blow to the earlier attempts with Stephen. See, *CE* February 1906, 20.

<sup>272</sup> The Oromo were previously termed 'Galla' by many Europeans in earlier days, and this expression was widely used in the missionary accounts of that day; Oromo is the preferred term for this ethnic group.

Palestine.<sup>273</sup> While not as quick as the turnaround by Paterson, dispensary work carried out by Mr Andries Ontong, another African, from 1892-1894, was also short-lived. Following Ontong's work at Lovedale, the medical work was perhaps more dormant than ever.

Stewart, who had performed medical service in the most minor capacity since Waterston's arrival, was absent from Lovedale from May 1890 until the end of 1894 (except for one 6 week visit). By the beginning of 1893, an author only identified as J.E.B. wrote to the editor of *The Christian Express* calling for a medical mission at Lovedale. With typically 'tragic tales' of life at the hands of "Kaffir" or Indian doctors for the "natives", the author derided the state of availability of Western medical treatment for Africans. J.E.B. included with this calls for a developed medical presence at the mission:

We do not think Lovedale itself has any idea of the great and pressing need of such a Mission. It would be a boon to Lovedale and a blessing to the surrounding stations.... Lovedale is doing good work now, and we have much to be thankful for in having such an Institution in our district, but the good done would be felt in many ways more clearly and be spread far more widely and reach many who know nothing of it now, if a Medical Mission were established at Lovedale.<sup>274</sup>

Shortly after this letter to the editor was printed, plans were beginning to become realised for a hospital situated at Lovedale. Yet the dreams only came to fruition due to the work of David Alexander Hunter, a businessman from Scotland.

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<sup>273</sup> Shepherd, *Lovedale South Africa*, 229-232; Young, *African Wastes Reclaimed*, 197-201, note especially the photo of the Oromo boys with Alexander Geddes, opposite pg 198. For more on Dr Paterson's missionary career in Hebron, in a missionary hagiographic portrayal typical of its day, see William Ewing, *Paterson of Hebron, the "Hakim"* (London: James Clarke, n.d. [c. 1925]).

<sup>274</sup> J.E.B., 'Medical Mission at Lovedale (Communicated)', *CE* January 1893, 14.

## ***The Rise of Victoria Hospital***

*D.A. Hunter*

If Stewart had long desired a hospital at the Lovedale campus, and Stephen had offered to financially back the dream,<sup>275</sup> it must be said that the person who put a plan into action was D.A. (David Alexander) Hunter.

From 1893 to 1894 Hunter toured Southern Africa, visiting about fifty missionary stations of varied denomination, backgrounds, methods of work. From this information gathering journey through the land, Hunter became convinced that medical missions maintained a very weak presence in the country, while the need was great. According to his count there were only five proper medical missionaries in the region south of the Zambezi, and by 1894 he had come on the Lovedale staff as an honorary worker, with a view to building a hospital at the mission. Hunter and other supporters, in line with much of the missionary thinking of the time, believed that a hospital would provide a number of benefits to the African people: physically, educationally, and socially. To work toward the goal of erecting a hospital, in 1895 Hunter travelled back to Scotland to personally head-up a fundraising appeal to bring the new hospital scheme to fruition. His letter seeking support for the work is a classic example of some of the Western characterizations about Africans, African

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<sup>275</sup> While not explicitly mentioned in an address given at a missionary conference, it is almost certainly John Stephen who was the man whom Stewart referred to as “another generous friend of African Missions at home” regarding the training of African medical men, and a hospital to accompany this training, an indication of Stephen’s seriousness regarding this subject. See, ‘Is the Training of Native Medical Men Desirable?’, *CE* August 1884, 118. Stewart also referred to Dr David A. Stirling, of Perth, Scotland, who visited South Africa with an interest in inaugurating a medical college at Lovedale. For further insight on Stirling and other figures, such as Dr Langham Dale, then Superintendent-General of Education in the Cape, from Dr Jane Waterston’s perspective see, Jane Waterston, Cape Town, to James Stewart, Lovedale, 24 February 1884, in *LJEW*, 186 (and footnote 36).

societies, and belief structures: ‘ignorant’, ‘superstitious’, and needing help.

Coupled with these suppositions were sincere sentiments so commonly displayed in the missionary discourse of that day:

One is appalled by the ignorance of even the educated Christian natives in matters relating to hygiene, and yet it is more their misfortune than their fault, for no one has gone to teach them about these things. They fear to go near a sick person, so that invalids are often left to die with neither proper medicine nor nursing, while among the heathen nothing better than the witch-doctor and his sorcery hold sway. A move in the right direction might be made by opening a hospital in some suitable centre.... Perhaps more than any other place in South Africa, Lovedale offers a suitable centre for such an effort.<sup>276</sup>

Hunter’s fundraising campaign resulted in the offer of a doctor and a nurse, if a hospital was constructed. In addition, the proposal also included the specific aim of training African nurses, a scheme that was lacking in the vast majority of Western missions within the whole of Sub-Saharan Africa, and especially notable when compared with medical mission education plans in other areas such as India and China.<sup>277</sup> Hunter garnered £100 from one donor early in his fundraising and by the end of 1895 his efforts had netted the Lovedale Hospital fund nearly £2000. By early 1897, property very near the Lovedale Institution had been purchased from the Alice Municipality and Hunter was petitioning the Cape Colony government in Cape Town for matching funds on a pound-for-pound basis. In his own words, he specifically emphasised Lovedale’s intention to train African nurses, and the then

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<sup>276</sup> D.A. Hunter, Glasgow, 10 October 1895, MS 16,457, LC CL.

<sup>277</sup> Compare, for instance, the report by Dr Mary West Niles, a medical missionary in Canton, who was working with one of the Chinese female medical *doctors* trained at their medical missionary centre: ‘A Chinese Woman Physician,’ *CE*, 1 September 1894, 138. Furthermore, a mission Nursing school had been established in Free Town, Sierra Leone, in 1892 by the Church of England (in connection with the Princess Christa Cottage Hospital). Prior to Lovedale’s nursing school, there had been medical schools and nursing training centres founded in Alaska (1), Sri Lanka (then ‘Ceylon’) (1), China (29), India (16), Japan (5), Korea (1), Malaysia (1), Iran (then ‘Persia’) (3), and Syria (1). Dennis, *Centennial Survey of Foreign Missions*, 113-114.

Prime Minister, Sir Gordon Sprigg, who was also Minister for Native Affairs, backed a grant for £1000 in a vote under Native Affairs, thereby ensuring the funds. Shortly thereafter, they received another £1000 from the government, bringing the total government contribution to £2000 for the initial construction of the Victoria Hospital.<sup>278</sup> Not all of the financing proved as straightforward as this, however.

While Hunter had been away in Cape Town trying to secure monies from the Colonial government, a local drive to finance the construction of a European ward in the hospital was begun by Rev. Henry Kayser. This retired London Missionary Society missionary eventually helped raise approximately £250 from people within Alice (with roughly one-fifth coming directly from people within Lovedale itself). In addition, another £250 was granted by the government after proper application had been made, on the pound-for-pound principle, bringing the Queen Victoria Jubilee Fund<sup>279</sup> to £500. The first problem arose in that the funds raised were not enough to build an additional ward that was in keeping with purpose and style of the hospital.<sup>280</sup> As well, the principal organisers of this Victoria Memorial Ward Fund (as it was also known) demanded that Lovedale indefinitely maintain the ward at its own cost, thereby adding certain, but unforeseen, long-term expenditures to the mission's budgetary costs. The Lovedale Hospital directors rebuffed this, arguing that it was much easier to build a ward than to maintain one, especially since the medical care of the white local community was not the central aim of the hospital and certainly not

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<sup>278</sup> D.A. Hunter, 'The Victoria Hospital, Lovedale', MS 16,457, CL, LC, 1. This undated, 3 page paper is a recollection of some of the early process in establishing the hospital, perhaps written circa 1910.

<sup>279</sup> This fund, and the name of the hospital, marked the 60<sup>th</sup> anniversary of Queen Victoria's accession to the throne in 1837. Many such honours were undertaken throughout the empire.



what donors in Scotland had given their money for. While the money was eventually given over to Lovedale and a hall built, the issue was a contentious problem, especially when, in September 1904, the Victoria Hospital stopped admitting whites. By 1906 the Hospital Board refunded the £500, which was eventually put toward reconstruction costs associated with the Alice Town Hall.<sup>281</sup> While not an especially groundbreaking turn of events in the overarching history of Lovedale, or even the medical history at the mission, this episode seems to be an especially apt example of varying objectives between missionaries, the local public, and wider governmental authorities. When such aims were not only divergent, but at odds with one another, animosity and suspicion sometimes crept in to decision making and future planning, as seen with Stewart's attitude toward the local members of the Victoria Hospital Board.<sup>282</sup>

#### *The Opening and Closing of Victoria Hospital*

With the vision of establishing a medical practice at the mission, along with a medical school, in February of 1898 the Free Church of Scotland Foreign Mission Committee recognised Dr James McCash as medical missionary to the new hospital at Lovedale, shortly before his departure from Scotland.<sup>283</sup> McCash, a member of

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<sup>280</sup> 'Victoria Memorial Ward, Lovedale Hospital', MS 16,457, CL, LC. This single page notice, printed by W. Dewey, was probably a public announcement from circa January 1898.

<sup>281</sup> D.A. Hunter, 'The Victoria Hospital, Lovedale,' MS 16,457, CL, LC, 2-3.

<sup>282</sup> James Stewart, Edinburgh, to D.A. Hunter, Lovedale, 19 September 1902, MS 16,457, CL LC, 1-2. "If anything is promised or hinted at they [the Government's representatives on the Victoria Hospital Board] will rigorously exact its fulfilment to an extent perhaps beyond what was intended. The Lovedale members will know to be on their guard. You will think I am needlessly cautious or suspicious. That is not so. The attempt was made long ago to wrest the library out of our hands and declare it the property of the district is a warning which it will be well to act on, and knowing the spirit generally, let us not be too simple."

<sup>283</sup> McCash had been appointed in June 1897, but was likely awaiting the final construction of the Hospital. 'The Victoria Hospital at Lovedale', CE May 1898, 67.

the United Presbyterian Church, had worked as a hospital superintendent in Glasgow, and the new matron for the hospital, Miss Wallace, originally from New Zealand, was previously labouring at Guy's Hospital in London. Having arrived in April, McCash began preparations for the opening of the hospital in the winter of that same year.<sup>284</sup>

On the 15 July 1898 the Victoria Hospital was officially opened with a great deal of local fanfare. Sir Gordon Sprigg, the Prime Minister of South Africa, toured the new facilities, gave a short address, and then declared the hospital open. At its inception, the stated aims of the hospital included: "to receive natives suffering from non-infectious diseases or accidents, and as a dispensary for out-patients [with] some space kept for Europeans as paying patients..."; "to train native women as nurses and native young men in ambulance work and first aid"; "to provide... a short course for Europeans going out as missionaries"; and "to diffuse, especially among natives, a better acquaintance with the treatment of patients during illness".<sup>285</sup>

McCash's first several months at the hospital witnessed typical medical mission work of this period. Occupying a priority in his practice were the Lovedale students and staff. As well, a number of African patients patronised the hospital as out-patients, totalling 1,714 visits, with McCash performing 364 home visits during the last six months of 1898.<sup>286</sup> Yet while the initial enthusiasm for what was hoped

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<sup>284</sup> *Ibid.*; 'Opening of the Victoria Hospital, Lovedale', *CE* August 1898, 113. In this latter piece, both McCash and Wallace are referred to as 'honorary missionaries'.

<sup>285</sup> 'Opening of the Victoria Hospital at Lovedale', *CE* August 1898, 117.

<sup>286</sup> 'The Victoria Hospital', *CE* January 1899, 5. Note that in 1898 Mr Gutama Tarafo worked as the dispenser, along with Miss Maya Koboka, as a nurse (probably in training). Miss Rosina Jingisna was reported on the Lovedale staff records as a nurse for 1899, and Mr Manama Molapo as dispenser. *Lovedale Missionary Institution Staff Reports Summary, 1872-1899*, AMKWT, Lovedale Box.

to be a long and sustained medical presence at Lovedale soon took an embarrassing turn for the mission. Wallace, the first Matron and nurse, departed after a year, and the subsequent Matron, Miss M.T. Prowse, along with McCash, left shortly after the hospital closed in 1900.<sup>287</sup> While most mission accounts of its closing have highlighted the fact that this was largely due to the Anglo-Boer War,<sup>288</sup> and understandably, as McCash entered into military medical service,<sup>289</sup> there may also have been minor management and financial issues which exacerbated the situation.

For, in letters from James Stewart, who was in Scotland at the time, to D.A. Hunter, Stewart inferred that facets of how the medical work at Lovedale under McCash, had been managed ought not to be repeated with the incoming superintendent, Dr Neil Macvicar. In one letter Stewart wrote:

I think the opening of the Hospital should be done somewhat gradually and with a clear view as to financial conditions or possibilities. We cannot lay the Hospital again on the [Lovedale] General Account, and must feel our way cautiously. The Dispensary can be re-opened at once, and the larger the numbers the better. Another point is the consideration of the native fee for dispensary attendance and medicine.<sup>290</sup>

He went on, in a subsequent letter: "I have mentioned to him [Macvicar] what is proposed about the Hospital, though his first care ought to be the institution, patients, and the general health there. We must put this matter right now, and not have a repetition of the inverted method followed by McCash."<sup>291</sup> Stewart, and possibly other Lovedale leadership, regretted the way in which financial matters were

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<sup>287</sup> The hospital closed, with very little public mention, in 1900, though McCash and Prowse stayed at Lovedale into 1901. *CE* January 1902, 6.

<sup>288</sup> For instance, Shepherd, *Lovedale South Africa 1841-1941*, 256, 345; Shepherd, *Lovedale South Africa 1824-1955*, 63.

<sup>289</sup> Shepherd, *A South African Medical Pioneer* (Lovedale: Lovedale Press, 1952), 83.

<sup>290</sup> James Stewart, Edinburgh, to David A. Hunter, Lovedale, 22 August 1902, MS 16,457, CL LC, 4.

<sup>291</sup> James Stewart, Edinburgh, to D.A. Hunter, Lovedale, 19 September 1902, MS 16,457, CL LC, 1.

handled, in addition to McCash's approach to medical mission work. Additionally, Stewart was not impressed with the Matron, Prowse – who was expected to return to her post as Matron when the hospital reopened<sup>292</sup> – though it is unclear whether this objection centred on her personality, management style, or missionary outlook.<sup>293</sup> With the hire of Neil Macvicar and Matron Mary Balmer, this chapter of a very minor and sporadic medical presence in Lovedale's history came to an end.

### ***Concluding Remarks***

Even with the medical work performed by Drs Stewart, Waterston, and Paterson, as well as the dispensary work carried out by Koboka and Ontong, the medical aspect of the Lovedale mission during the last few decades of the 19<sup>th</sup> century was altogether substandard, especially considering the possibilities. Without a desire to be overly critical of the missionaries themselves, and while fully acknowledging the apathetic attitude displayed by the Foreign Mission Committee in Scotland,<sup>294</sup> the leadership of Lovedale did not exert a sustained effort for any

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<sup>292</sup> CE January 1902, 6.

<sup>293</sup> “You said in one letter that you thought one [Matron] could be got in the Colony. I do not know if you mean Miss Prowse; but if so, I think that requires much consideration and a limited term of engagement.” Stewart to Hunter, 22 August 1902, MS 16,457, CL LC, 4.

<sup>294</sup> In what might be seen as a rather infamous example of the United Free Church's history regarding their lack of sending out a medical missionary can be found in 1901. At the time of King Edward VII's coronation, the Governor of Gondar, Kentila Ghebroa, explicitly asked the UFCS, on behalf of Ras Makonen Woldemikael Gudessa (father of Ras Tafari Makonen, also known as Haile Selassie), whom he accompanied to the coronation, if they would send a medical missionary to Addis Ababa to work amongst the people there. The reply later came that the UFCS might be able to get a medical missionary to spend a portion of their holiday in Ethiopia. In reporting this, *The Christian Express* did

expansion in its medical mission forays during much of the 19<sup>th</sup> century period. And when it attempted positive changes, the plans fell through.<sup>295</sup> This situation only began to change when D.A. Hunter became proactively involved in a well executed campaign for the erection of the Victoria Hospital. Yet even the opening of the hospital could not be sustained. With the superintendent, James McCash, leaving the hospital and lending his medical service to the British forces during the Boer War, the hospital was shuttered and medical work once again absent.

For all the shortcomings in the approach to medical work carried out by Lovedale in this period, however, it is remarkable that the two most important medical workers who did contribute were otherwise marginalised within this field: a female doctor and an African dispenser. Jane Waterston is one of the most intriguing personalities in medical mission studies during this time. As one of the first women of Scotland to qualify for a degree in medicine, she was subsequently reduced to a status of *persona non grata*, especially as a well qualified medical missionary, by Robert Laws at the Livingstonia mission in Malawi. With this troubled experience in her immediate past she nevertheless performed well in her capacity as the major medical missionary presence of Lovedale, if only for a couple of years. Govan Koboka, as an African medical assistant/dispenser was also relegated to a junior status. Even so, Koboka's experience in varied medical backgrounds served him well and garnered him a high reputation for his expertise within his medical field.

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not blame the Foreign Mission Committee so much as the church in Scotland, but it nevertheless demonstrates a lack of will on their part. *CE* January 1903, 2.

<sup>295</sup> Dr Stewart apparently wrote a letter to the acting principal of Lovedale from Scotland in 1891 to say that monies and permission had been approved for a hospital at Lovedale but in the end, this came to nothing. And just a year later, he spoke with an African Medical Society about establishing a medical course for Africans with an accompanying hospital for training, though this too failed. See, 'A Great Day's Work', *SAO* January 1938, 14.

Though a dispenser, Koboka was largely the only medical presence at Lovedale during his years of service. And finally, without the ability to quantify the effects of their work through external witness, it is eminently clear from the Lovedale records that some of the local African population found Waterston and Koboka welcoming enough in their medical treatment to patronise their practices in large numbers.

## Chapter 3: Dr Neil Macvicar and Matters of Belief

### Introduction

In line with some of the research focused on noteworthy individuals in medical missions, this chapter begins the concentration of this thesis, which centres on important aspects of the thought and work of Dr Neil Macvicar. A Scottish Presbyterian medical missionary, Macvicar was a long-standing and active participant of the Lovedale mission in Alice, South Africa, during the first few decades of the twentieth century. And though Macvicar retired (to Johannesburg) from his post as Superintendent of the Victoria Hospital in 1937 after 35 years of service, he did not give up his vigorous role in addressing various South African issues. Indeed, it was during this period that he wrote some of his most revealing, driven, and articulate work. The year 1943, alone, saw eighteen articles and four book reviews published in *The South African Outlook* (formerly *The Christian Express*)<sup>296</sup> – the missionary journal published at Lovedale).

Though the Victoria Hospital was the focal point of his medical labour and devotion – as superintendent, physician, and surgeon for many years<sup>297</sup> – Macvicar was anything but confined to his work within these capacities. As an educator, he was a member of the small group who founded the South African Native College at Fort Hare (later Fort Hare University), working for years to bring about its inception and serving as Secretary of the Inter State College Executive Committee from

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<sup>296</sup> Hereafter, these magazines are abbreviated as *SAO* and *CE* respectively.

<sup>297</sup> For more on the medical work of the Victoria Hospital, see chapter 5.

December 1909 to July 1911.<sup>298</sup> As already alluded to, he authored dozens of articles, as well as a number of books, pamphlets, and book reviews on myriad subjects. Teaching was another area of involvement, with classes for African nurses and hospital assistants, not to mention health courses at the South African Native College and the Lovedale Institution. An additional role dear to Macvicar was his involvement with preaching, delivering devotions and participating in services for Lovedale students and hospital patients alike.<sup>299</sup> As an advocate for better public health, he researched, reported on, and worked to influence both policies as well as the general public on factors ranging from the effects of alcohol, to the interaction between mission hospitals and the National Health Commission, to a call for the establishment of a Ministry of Food.<sup>300</sup> Perhaps needless to say, he was an extraordinarily active medical missionary, with varied interests and arenas of involvement.

While Macvicar's participation in some of these capacities has been covered and touched on elsewhere,<sup>301</sup> this chapter explores the interaction between his worldview as a Western-trained medical doctor and his understanding of, and hostile

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<sup>298</sup> For more on Macvicar and education, see chapter 6.

<sup>299</sup> Preaching was of particular importance to Macvicar after his work with the Church of Scotland mission at Blantyre at the end of the nineteenth century, and his consequent 'dismissal' from that work. The subject came up as an important discussion point with James Stewart before securing the job at Lovedale. See CL, LC, MS 16,457, James Stewart, Edinburgh, to D.A. Hunter, Lovedale, 11 July 1902, 3.

<sup>300</sup> See Macvicar, 'Alcohol and Cold', *CE*, March 1912, 34–35; 'The Christian Council of South Africa and the National Health Services Commission', *The International Review of Missions*, 33 (1944): 407–14; 'A Ministry of Food Needed', *SAO*, April 1943, 52.

<sup>301</sup> See R.H.W. Shepherd, *A South African Medical Pioneer: The Life of Neil Macvicar* (Lovedale C.P.: The Lovedale Press, 1952); M. Gelfand, *Christian Doctor and Nurse: The History of Medical Missions in South Africa from 1799–1976* (Sandton: The Aitken Family and Friends, 1984). There are also books related to Lovedale and Fort Hare in which Macvicar is discussed: see, for example, R.H.W. Shepherd, *Lovedale, South Africa: The Story of a Century, 1841–1941* (Lovedale, SA: Lovedale Press, 1940).



action against, particular African<sup>302</sup> belief – namely, the topics of ‘superstition’ and ‘witchcraft’ (as he referred to them). I begin by looking at Macvicar’s conception of African thinking on causes of sickness, disease, and death. Attention then turns to his work to both eradicate as well as replace such beliefs. The second portion of this chapter examines his scientifically informed belief structure and its influence on his theology and approach to medical missionary work.

## **Belief about Beliefs**

### *‘Superstition’, Witchcraft, and Spiritual Entities*

Like many other missionaries of his day, who seemed to enjoy relating instances of stories they heard in their missionary magazines,<sup>303</sup> Macvicar was convinced that the more “primitive Native”<sup>304</sup> believed nearly all serious illnesses and even death itself were likely brought about through an interaction of three factors: other people; spiritual agents; and natural/magical forces.

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<sup>302</sup> The term ‘African’, of course, is very broad and general. However, Macvicar used such generalisations, and largely for good reason – the individuals whom he interacted with, both directly and indirectly, were of varied ethnic backgrounds throughout southern Africa. I have taken the liberty of using the term ‘African’, where he would typically have used ‘Native’, though allowing him to speak for himself in all quotations.

<sup>303</sup> Such sentiments within the missionary publications often highlighted particular stories of their interaction with Africans. For example, ‘Conversion of a Witch-Doctor’, *The Switzerland of South Africa*, in *CE*, March 1894, 38; ‘Report of the Mission at Main, Tembuland, for 1902 -Heathen Superstition’, *CE*, June 1903, 87; ‘Not Troubling to Think – It is Magic’, *The South African Health Society Magazine*, January 1930, 1; D.J.N.W., ‘Christianity and African Superstition’, *Other Lands*, January 1945, 31-32.

<sup>304</sup> This terminology was typically employed to refer to those who had not changed habits of social and private life to European manners – such as clothing, housing, education and religion. Such terms were often employed against ‘civilised’ Africans, within the missionary discourse (and most notably with pictures to juxtapose the contrasting changed ‘status’ or transformation due to missionary

Among the South African Bantu the prevalent theory of disease is that it is due to some hostile personal influence, emanating either from the spirit of a dissatisfied ancestor or from a malevolent neighbour, or even from some one to whom no motive can reasonably be attributed, as for the example of the mother of the victim.<sup>305</sup>

To his reckoning, imaginative speculation and highly subjective blame occupied the place of clear and non-judgemental investigation (hallmarks of ‘proper’ scientific theory and thought which he believed pervaded the Western system of thought).

In terms of its *possibility*, Macvicar was sympathetic to the idea of malicious human activity as the cause for sickness or even death. However, the probability of widespread intentional human activity as the source of harm (such as poisoning) did not seem reasonable to him. He was convinced that illnesses ought to have been blamed on the natural unintended transference of germs/disease, due in part to what he felt were low standards of cleanliness and hygiene in African traditional domestic life, a not-uncommon sentiment among Westerners.<sup>306</sup> In an article entitled ‘Kafir Poisoning’, he recounted an experience he had with a patient. Having gone to the ill man’s hut and finding him there with the patient’s friends around him, Macvicar was temporarily perplexed about the cause of the man’s pain. He finally concluded that dysentery was to blame and treated the ill man accordingly. At the time, however, both the patient and his friends were convinced that ‘poison’ was the cause of the malady. Macvicar’s reflection and conclusion on the matter were summarised:

The question arose in my mind: Is this so-called kafir-poisoning just another name – invented perhaps to meet European ideas half-way – for witchcraft? Or is there any real basis in fact for the idea? My own further experience has inclined me to take the former view.<sup>307</sup>

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involvement). See, for example, the pictures and accompanying text in J. Stewart, *Lovedale Missionary Institution, South Africa* (Lovedale, South Africa: Lovedale Mission Press, 1884).

<sup>305</sup> Macvicar, *Sidelights upon Superstition* (Lovedale: The Lovedale Press, 1939), 2.

<sup>306</sup> Hokkanen, *Quests for Health*, 251-52; Good, *The Steamer Parish*, 275, 330.

<sup>307</sup> Macvicar, ‘Kafir Poisoning’, *South African Medical Record*, 13 January 1917.

In greater detail, he described how he believed there were certainly documented cases for poisoning, but did not think that even some common southern African formulas for poison would result in the intended malevolent consequences. While such sentiment was echoed by some, not all Westerners were as hostile to African traditional methods of healing, especially related to herbalist and African pharmacopoeia, as Macvicar.<sup>308</sup>

Upon questioning a couple of African men on the subject, Macvicar reckoned that only one of the six stated concoctions for poison would result in the loss of life and that ‘superstitious’ notions were even entangled with what were, in reality, benign physical ingredients. For Macvicar’s mindset – tied both to a lens of the post-Enlightenment natural world (devoid of supernatural explanations) and an accompanying optimistic bent toward future progress and advances<sup>309</sup> – there was insufficient evidence to justify belief in the widespread reporting of such ‘poisonings’. Instead, he continually believed that infectious diseases, such as enteric fever or dysentery, were to blame for the vast majority of ‘poisonings’.<sup>310</sup>

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<sup>308</sup> One writer was especially suspect of herbalists’ non-scientifically tested prescriptions, F.G. Cawston, ‘Superfluous Medicine’, *The South African Health Society Magazine*, January 1933, 3-4.

Especially by the 1930s, other medical doctors or scientists, however, were quite interested in South African traditional methods of healing and *materia medica*, often attributing admiration for traditional healers’ knowledge and techniques. See: J.M. Watt, ‘Use of Plant and other Material as Medicine, Charm, or Poison’, *Bantu Studies* 2 (1923-1926), 215-216; J.M. Watt and Marie G. Brandwijk, ‘Suto (Basuto) Medicines’, *Bantu Studies* 3 (1927-1929): 73-100, 155-178, 297-319; J.M. Watt and N.J. v. Warmelo, ‘The Medicines and Practice of a Sotho Doctor’, *Bantu Studies* 4 (1930): 47-63; Felix, ‘Native Medicines’, *SAO*, August 1931, 156-157.

<sup>309</sup> Peter Bowler, *The Invention of Progress: The Victorians and the Past* (Oxford: Basil Blackwell, 1989), 8-11.

<sup>310</sup> Macvicar, ‘Kafir Poisoning’, 2-4. See also an article, written by an African Minister who only went by the initials I.W., in *The Christian Express*, which largely agrees with Macvicar, though has a few notable differences of opinion: ‘Witchcraft’, *CE*, October 1906, 155-56.

In addition to humans as the cause of sickness through the use of magical and malicious means, Macvicar also identified other entities as agents of illness and death in the African worldview. 'Evil spirits', which commonly took the shape or appearance of animals or 'magical forces of nature' (such as a river) were often blamed for bringing about calamity.<sup>311</sup> Drownings in rivers were not simply tragic occurrences, but events brought about by the river's (conscious) activity. Macvicar recounted that there was a belief among some of the 'primitive' people that the river itself, as a conscious entity, was to blame for the tragedy.<sup>312</sup> In another instance, he recalled how some schoolgirls (from Lovedale) did not try to aid a classmate who was seen floating in a river, but instead ran for help, because they feared the 'river spirit'. Interestingly, he thought that such belief was actually of a higher standing than belief in witchcraft; more 'advanced' in its still 'superstitiously based' conclusion. For, whereas witchcraft or cases of poisoning were based on nearly altogether false or highly subjective social assumptions, the belief in some natural means as the cause for illness or death was fundamentally true. That is to say, the physical origin was identifiable (a river, for example) and the presence of an objective (inanimate) causal agent was what the 'scientifically minded' Macvicar found to be of utmost importance, never mind whether or not they believed an inanimate object could be animate.<sup>313</sup> Such a demonstration of what Macvicar believed was more developed reasoning is an intriguing subject, as it seems to allude

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<sup>311</sup> See the article by one of Macvicar's colleagues in the South African medical field which references a similar story of the 'river spirit', with comment: J.W. Weir, 'Some Notes on Kaffir Medical Practice', *South African Medical Record*, 15 August 1904, 147-148.

<sup>312</sup> Macvicar, 'The Racial Experience of the Bantu. – I.', *CE*, November 1920, 165–66.

<sup>313</sup> Macvicar, 'The Racial Experience of the Bantu. – II.', *CE*, December 1920, 181.

to elements of societal ideological advance. While this is an important topic of exploration, it is one which must be left for discussion elsewhere.<sup>314</sup>

### *Consequences*

Tantamount in importance to these beliefs were the conclusions that Macvicar reached regarding the secondary negative effects of such ideology. Through his writings, he identified a number of problems that arose from ‘superstitious’ beliefs. His greatest concerns were the incorrect identification of various sicknesses and consequent false treatment. There was also the actual spread of particular diseases within the African communities. Additionally, there were social matters that greatly troubled him; for, in his opinion, the belief in witchcraft seemed to spread social disharmony as suspicion, blame, accusations, marginalisation, retribution, and revenge grew within a community. Finally, Macvicar hinted at the possibility of disease and sickness spreading from the black South African communities to white South Africans, if left unchecked.

While often paternalistic regarding some portions of black African society and harsh in his estimation of some aspects of African belief about health care, there is no reason to question Macvicar’s concern for his patients and their well being. He thus demonstrates a common ambiguity of medical missions during this period: strong disregard for much of the cultural norms and manners of thought, but great

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<sup>314</sup> For some of Macvicar’s thoughts on this related subject of progress – ethnically, socially, racially, and regarding civilisation – see, for example, Macvicar, ‘Christ and Race Questions’, *SAO*, July 1925, 157–59; *Side-Lights Upon Superstition: Western Civilization and the Bantu* (Johannesburg: South African Institute of Race Relations, 1947); *Africa Tomorrow?* (Johannesburg: South African Institute of Race Relations, 1947).

concern for the people and ‘progressing’ their civilisation.<sup>315</sup> In this way, perhaps, Macvicar demonstrates the paradox of continued belief in humanitarian progress amid growing doubt about the inevitable advance of mankind, so pervasive in segments of late-nineteenth and early-twentieth century white South African thought.<sup>316</sup>

In his first full report of the Victoria Hospital as Superintendent, for instance, Macvicar pointed out to the reader that he and Matron Mary Balmer took great care and time to explain, as exhaustively as possible, ‘the nature of his illness to him [any patient], giving him advice upon such subjects as diet, change of residence, disinfection of sputum, the importance of fresh air, etc.’<sup>317</sup> All of this was part of an effort toward replacing the patient’s previously held understandings as to the nature of disease contraction as well as proper treatment and preventative measures. He went on to remark: ‘It is one of the special duties of medical missions in Africa to enlighten the native mind as to the real nature and causes of disease ...’<sup>318</sup> Just a year later Macvicar wrote on the perceived inevitability, through the dissemination of information and instruction as well as the presence of the hospital, of the slowdown in the spread of phthisis.<sup>319</sup> Such remarks bear witness to the confidence he placed in

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<sup>315</sup> N.N. Miller, in Good, *The Steamer Parish*, back cover.

<sup>316</sup> S. Dubow, ‘The Elaboration of Segregationist Ideology’, in W. Beinart and S. Dubow, eds, *Segregation and Apartheid in Twentieth-Century South Africa* (London: Routledge, 1995), 154–55.

<sup>317</sup> Macvicar, ‘Victoria Hospital, Lovedale: Report for the Year 1903’, *CE*, February 1904.

<sup>318</sup> *Ibid.*

<sup>319</sup> ‘Lovedale Missionary Institution’, *CE*, January 1905, 3.

direct health care and public health initiatives, and help to explain why he emphasised the importance of more holistic health care education.<sup>320</sup>

Fundamentally, Macvicar thought that the advances in Western biomedicine were far beyond any African remedies, even those given by herbalists, and what he may have recognised as ‘legitimate’ methods of African healing (never mind ‘witch-finders’, etc.).<sup>321</sup> In this regard, he stood within the mainstream current of the Euro-American missionary discourse;<sup>322</sup> there were, however, certainly notable exceptions, such as David Livingstone or Andrew Smith, who demonstrated a much deeper respect for African understandings of herbal remedies and the knowledge of local *materia medica*.<sup>323</sup> Macvicar believed that most black South Africans did not

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<sup>320</sup> In his argument for health classes in schools, modelled on efforts in the U.S., Canada, and the U.K., he wrote, “The lessons should begin with outward habits such as cleanliness and end with inward, such as self-control”. Macvicar, ‘The Argument for Health-Teaching in Schools’, *CE*, August 1908, 117.

<sup>321</sup> Macvicar’s comprehension of, and interaction with, African traditional practitioners is best left for another discussion, due to space constraints. For more on his writings about this topic of practitioners and medicine, see *Side Lights*, and his series of articles in *The Christian Express* on ‘Advertised Medicines’ from December 1910 to February 1911 and ‘The Report from the Select Committee on Patent Medicines’ from March to September 1915.

<sup>322</sup> The following statement, from a fellow Scotsman, and though early in the medical missionary endeavour, sums up this view rather well: ‘... the advancement of medical science in countries where ignorance in regard to it, and where a medical practice, founded on grossly erroneous principles, entails a fearful amount of suffering on the victims of disease in such countries.’ William Swan, ‘The Importance of Medical Missions’, in *Lectures on Medical Missions*, 91.

For an example of a more nuanced view on the difference between the efficacy of herbalists and ‘witch doctors’, comes the observation from an American Brethren missionary to southern Zimbabwe in the early twentieth century: ‘It would be unjust to say that their doctors never use remedies; in fact, they have many herbs which they use and some of these are very efficacious ... Notwithstanding that they have these remedies, yet, in practice, this is often so mixed with charms and other superstitious ideas, that it is difficult to tell wherein the real remedy lies.’ H.F. Davidson, *South and South Central Africa: A Record of Fifteen Years’ Missionary Labors among the Primitive Peoples* (Elgin, Illinois: H. Frances Davidson, 1915), 182; See also the opinion of a contemporary missionary doctor in South Africa, J.B. McCord, with J.S. Douglas, *My Patients Were Zulus*, 88–99.

<sup>323</sup> Gelfand, *Livingstone the Doctor*, 5–8; Andrew Smith, *A Contribution to South African Materia Medica, Chiefly from Plants in Use among the Natives*, 3<sup>rd</sup> ed. (Lovedale: The [Lovedale] Publishing Department, n.d. [1895]). Note the high regard in Smith’s words regarding one European woman and the knowledge held by traditional Xhosa healers: ‘Among the ladies of the Mission, I have to make very warm acknowledgments to Mrs Young of Main. As formerly at Lovedale (then Miss Weir), so now she constantly makes use of the medical art as a part of Christian work, and owing to that, and

understand even the most basic elements of health care and were sometimes dying as a result.<sup>324</sup> In a statement summing up part of the purpose behind Victoria Hospital, he addressed this very issue:

It was further evident that the Native people as a whole were sadly ignorant of the laws of health, that certain preventable [*sic*] diseases were spreading among them and causing untold misery and that literally nothing was being done to shew them how to combat these diseases. The idea too that disease and death are often the result of the malign influence of a neighbour who has bewitched the sufferer, had still a great hold over the minds of the Christian Natives ...<sup>325</sup>

Such remarks outrightly stating an obvious purpose of the hospital work were probably implicitly assumed by most white South African and Scottish readers, though Macvicar typically made reference to this subject matter in yearly reports. A further conclusion, taken from a hospital report for 1922, demonstrates the vigorous intent on his part:

The sufferings of the Native people are in large measure the outcome of poverty, *ignorance*, and squalid and vicious surroundings. It seems right therefore to direct as much effort as possible towards enlightening the people and aiding them to obtain healthier conditions of living.<sup>326</sup> [emphasis mine]

It seems clear that he equated African understandings and treatments with suffering and further ill health for the African population.

But in addition to the physical results of such a belief system, Macvicar also highlighted the social destruction of ‘superstitious’ beliefs. Suspicion, un-neighbourliness, and cruel or malicious acts were seen by him as foundations of a

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her personal influence, and familiarity with the language, she has access to information from the Kaffir professionals, where others find a sealed book. The value of all her communications is enhanced by the results of her own experiments in the uses of plants.’ The divided opinion between these earlier figures and Macvicar may be, at least in part, due to advances in Western medical science (best witnessed in Koch’s identification of *Mycobacterium tuberculosis*, the cause of tuberculosis, in 1882) during the latter half of the nineteenth and early twentieth centuries. Such leaps in knowledge led many to an excessively optimistic assumption in the ‘conquest’ of disease.

<sup>324</sup> Macvicar, ‘The Argument for Health-Teaching in Schools’, *CE*, August 1908, 117-118.

<sup>325</sup> Macvicar, ‘The Victoria Hospital, Lovedale’, *CE*, October 1906, 208.

<sup>326</sup> Macvicar, ‘Report of the Victoria Hospital, Lovedale, 1922’, *SAO*, February 1923, 38-39.



society that retained belief in witchcraft as the primary causative agent of disease, illness, and death.<sup>327</sup> In accusing people around them of causing sickness, through bewitching, ‘evil spirits or other occult agencies’, Macvicar saw an overarching cloud of an ‘unspeakable amount of ill-feeling among neighbours’ hanging over much of Africa.<sup>328</sup> To his mind, such an ill-begotten system of belief led to a flawed social order; one in which suspicion grew into hatred and consequently into hateful acts.<sup>329</sup> All of this contravened not only his medical and scientific beliefs, but his personal core values as a Christian missionary.<sup>330</sup> Whether it was an act of retributive murder, the driving of people from their homes and villages, harassment and gossip, or outright accusations<sup>331</sup> – all due to belief in witchcraft – Macvicar concluded:

The belief in witchcraft poisons the whole social life of a community. M. Junod speaks of ‘the terrible power of hatred’ which the Natives possess. How can it be otherwise when they really believe that their misfortunes, and especially their bereavements, are due to the spiteful interference of their neighbours?<sup>332</sup>

One last facet must be mentioned regarding what Macvicar believed were the effects of belief in witchcraft, spiritual agents, and other ‘superstitious’ ideas as causes for ill health and disease. While further sickness and worsened health was one

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<sup>327</sup> Macvicar, *Sidelights upon Superstition*, 4.

<sup>328</sup> Macvicar, ‘Victoria Hospital, Lovedale: Report for the Year 1903’, *CE*, February 1904, 21. See also Macvicar, ‘The Racial Experience of the Bantu – I’, 165.

<sup>329</sup> Macvicar, ‘Victoria Hospital, Lovedale’, *CE*, October 1906, 208.

<sup>330</sup> Macvicar, ‘Victoria Hospital, Lovedale: Report for the Year 1935’, *SAO*, February 1936, 43. Note that these categories of thought were not separated for Macvicar, as I contend in the latter portion of this article.

<sup>331</sup> In his work *Sidelights upon Superstition*, Macvicar provides a short chapter, ‘Things that happen in a Christian Village’, outlining the travails of one man accused of being a sorcerer for over twenty years. Macvicar notes in the beginning of the following chapter that the tendency at that time (originally published in 1909), was ‘to concentrate suspicion upon one person in a community instead of, as formerly, implicating anyone who happened to be either obnoxious to the family or a rich person whose property was worth confiscating’. This is noteworthy not simply for the aspect of reduced accusations, but for Macvicar’s assumptions on the reason for witchcraft accusations in the first place. See *Sidelights upon Superstition*, 11.

<sup>332</sup> Macvicar, *Sidelights upon Superstition*, 5.

matter for concern – due to what Macvicar was convinced were incorrect identifications of ill health causation – and (often consequentially) ineffective treatment and social disharmony within black African communities was another, he brought forward a third implication from this worldview. Essentially, Macvicar thought that the traditional African belief structure, and the physical ailments which ensued as a result, ought to be a cause of great concern particularly for white South Africans. In an article on the high rate of incidence and growing dissemination of typhus within South Africa, he began by lamenting the fact that, if it were a cattle disease ravaging the country, there would have been public clamour by the white community for governmental action (thereby trying to shame the reader with the obvious contention that human lives were indeed much more precious than cattle). While never explicitly identifying the role of ‘superstitious belief’ as a reason for the spread of disease among the ‘Native people’, he echoed other reasons for the endemic presence of typhus among them: ignorance about the cause,<sup>333</sup> poor personal hygiene, and the presence of vermin within housing all contributed to the disease’s presence and growth. He then succinctly covered a breakdown of what he thought could potentially happen in the future: up to, “50% of the Native people are liable to be potential carriers of the disease; that as travel increases the infected area is likely to widen ... [and] that white people who have Natives helping in their homes are exposed to infection, scrupulously clean though they may be in their own persons”.<sup>334</sup> While this example may not be identified as a direct result of

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<sup>333</sup> Macvicar points out that “[m]ost of the recent medical evidence supports the view that lice alone are the carriers of typhus just as mosquitos [*sic*] are of malaria”, demonstrating that even among the European medical establishment there was still much being learned (and still yet to learn at that time).: Macvicar, ‘Typhus’, *CE*, August 1920, 117.

<sup>334</sup> Macvicar, ‘Typhus’, *CE*, August 1920, 117.

‘superstitious’ belief, it does demonstrate another aspect of the secondary consequences of what Macvicar believed was a blatantly false belief structure – the transference of disease between black and white communities.<sup>335</sup>

In addition to the physical spread of disease, Macvicar also identified what he termed a ‘more subtle and deadly’ aspect of ‘superstitious’ thought: the transference of such a worldview from the ‘Africans’ to the ‘Europeans’.<sup>336</sup> Macvicar warned against a kind of ideological osmosis that would be, in his opinion, a regression for the ‘Europeans’ – a return to their very own superstitious past from which they had progressively evolved as a civilisation. This would, he believed, result in an eventual,

serious and widespread mental and spiritual deterioration ... The only conclusion seems unavoidable that, in the long run, the only hope for the White race lies in the conversion and enlightenment through education of the Native races. If the White race is to save its own soul, it must face up to this gigantic task.<sup>337</sup>

In summary, Macvicar contended that African understandings of disease causation and treatment were almost wholly inappropriate and inaccurate. He believed there was very little evidence of the most important aspects of Western-based scientific investigation within the traditional African methodology of healing – objective observation, testable theorising, and direct natural causation for illness or death. Instead, he summed up the majority of their system as based upon aspects of witchcraft and the involvement of other ‘unenlightened’ notions. And in his opinion, three intermingling repercussions would result from such belief: continued physical suffering and the spread of disease among the black South African populations;

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<sup>335</sup> One cannot help but wonder if Macvicar specifically wrote this to prod white South African public interest in black South African public health issues – essentially trying to direct a mindset to a broader inclusiveness: from ‘us’ and ‘them’ toward ‘we’. If the reader cringes at the self-centred tone of the work, it may have been specifically employed in this way to enact interest and attract change.

<sup>336</sup> Macvicar, ‘The Argument for Health Teaching in Schools’, *CE*, August 1908, 118; *Sidelights upon Superstition*, 15.

social dissonance and an increase in the marginalisation, cruelty, and persecution of certain segments of society; and, finally, the spread of both physical diseases as well as the ‘false’ ideologies themselves – from the black South African population to the white South African populace. We now turn to his inseparable dual reaction to this state of affairs, the eradication of such belief and its replacement with Western scientific understandings of both the cause and treatment for varying ills.

### **Eradicate and Replace**

While this section outlines Macvicar’s twofold approach on the subject of his response to African disease causative theory, it should be made explicitly clear that there was really no bifurcation in his aims of eradication and replacement. Firstly, Western-informed health education was seen as a pre-eminent force in working against the African belief structure.<sup>338</sup> He therefore laboured to educate an African elite – especially nurses, hospital assistants, and teachers – convinced that *they* would be able to communicate most effectively the Western scientific truths on health-care issues.<sup>339</sup> Second, Macvicar aimed to educate the masses, or at least provide material that would prove informative for myriad issues surrounding heightened health care –

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<sup>337</sup> *Sidelights upon Superstition*, 16.

<sup>338</sup> L.B. Kumwenda, ‘African Medical Personnel of the Universities’ Mission to Central Africa in Northern Rhodesia’, in Hartwig, *Healing Bodies*, 194, 200.

<sup>339</sup> This employment of indigenous workers for health-care transformations is really a shadow of the reality in religious conversion used by the missions. As is increasingly being seen in current literature, the everyday work carried out by the foreign missionary presence was in fact performed by the native Christians, both formally recognised (i.e. evangelists), and not (i.e. lay converts and workers). See, for example, T.J. Thompson, *Touching the Heart: Xhosa Missionaries to Malawi, 1876–1888* (Pretoria: University of South Africa, 2000).

such related subjects included food and nutrition, personal hygiene, health, housing, or various diseases.

### *Educated Elite*

From the very beginning of his time in South Africa, Macvicar set about the important task of training young African women as nurses (following the gendered norms within the British Empire), becoming the first, along with the Victoria Hospital Matron, Miss Mary Balmer, to undertake this work in all of South Africa.<sup>340</sup> Though the hospital had been closed for part of the Boer War, by the time it reopened in November 1902, under Macvicar's superintendency, there were two African nurse-probationers training (with room for one more).<sup>341</sup> At the end of their first year, these probationary nurses had received 24 demonstrations and lectures, ranging from eight lectures on 'Anatomy' to more particular subjects such as 'Dysentery' and 'Principles of Wound Treatment'.<sup>342</sup> By October 1906, the community celebrated as Nurse Cecilia Makiwane,<sup>343</sup> one of the first to train at Victoria Hospital under Balmer and Macvicar, had completed her course and been appointed to Butterworth Hospital.<sup>344</sup>

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<sup>340</sup> D. Gaitskell, 'Women, Health and the Development of Medical Missions: Some South African Reflections', in K. Hallencreutz, ed., *Gender, Poverty and Church Involvement* (Uppsala: Swedish Institute of Mission Research, 2005), 57–77.

<sup>341</sup> Macvicar, 'Victoria Hospital', *CE*, January 1904, 7.

<sup>342</sup> Macvicar, 'Victoria Hospital, Lovedale: Report for the Year 1903', *CE*, February 1904, 22.

<sup>343</sup> She was the daughter of Rev. Elijah Makiwane, an influential Xhosa Presbyterian minister, intellectual, and leader in the late nineteenth and early twentieth centuries. Her place at the forefront of this emerging profession seems to demonstrate that at least this portion of the elite black South African community were willing to go forward in the new work.

<sup>344</sup> By December 1907, Nurse Nokose Matade, the second graduate of the Nurse Training at Lovedale, had taken a job with the Colonial Colliery Companies, working in conjunction with their coal mines.



The two captions written on the photo read, “Hospital Staff 1908”, and “Dr Neil Macvicar and the Matron Mary Balmer with the black staff of the Victoria Hospital Lovedale about 1908”. This is probably the oldest surviving picture of the Victoria Hospital staff, and likely from a date earlier than the handwritten comments on the photograph suggest.

Unfortunately, no names were recorded.<sup>345</sup>

Makiwane, who passed the Cape Colonial Medical Council exam on 7 January 1908, was in fact the first black South African nurse to complete a full hospital nursing course,<sup>346</sup> later becoming the first registered black nurse in all of colonial Africa.<sup>347</sup>

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By this time, Butterworth Hospital was also seeking another trained nurse from Lovedale. See *CE*, December 1907.

<sup>345</sup> AMKWT 1679/SH 032/H/B. I believe that this picture is from a date slightly earlier than the quotation on the back of the photo suggests. For the woman on the furthest left, standing, is Cecilia Makiwane, the first black registered nurse in South Africa, and note the date written on the photograph on the following page (also labelled 1908). Perhaps this photo was taken at the time of her completion of the hospital-based coursework in 1906. I believe one of the young men is Mosedi Makamase, see *CE* October 1906, 214.

<sup>346</sup> *CE*, October 1906, 214.

<sup>347</sup> For more on this discussion, with insight on a range of important issues on this subject, see Chapters 1 and 4 in S. Marks, *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession* (New York: St. Martin’s Press, 1994).



“Macvicar and nurses and medical aids, c. 1908.”  
 “Top: David Msikinya, Joseph Mgobozi, Stewart Motebang, & Andrew Mothlaga  
 Bottom: Esther Chain, Dr Neil Macvicar, Anna Mcobela, & Nombie Goduka”.<sup>348</sup>

The nurse-training programme at Victoria Hospital continued to grow over the decades, and for those who were accepted, it proved rather generous: no fees, free board, work clothes and shoes provided, and even a yearly stipend.<sup>349</sup> In 1935, Macvicar compiled a map of South Africa with marks signifying the locations of salaried employment by Lovedale nursing alumnae. While the largest concentrations of these nurses included the Witwatersrand, Port Elizabeth, Cape Town, and Lovedale itself, there were literally dozens of locations scattered throughout the map,

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<sup>348</sup> AMKWT 1681/SH 032/H/B.

<sup>349</sup> Macvicar, ‘The Training of Native Hospital Nurses’, *CE*, February 1919, 24.



demonstrating a wide dissemination of educated nurses, though limited in job opportunities due to the increasingly suppressive political environment.<sup>350</sup>



Dr Macvicar and the staff of the Victoria Hospital. The accompanying text from the photo:

“Dr Neil Macvicar and acting Matron Sister Gregory with nursing staff;  
on front verandah of the Victoria Hospital, Lovedale, about 1918 or 1919.”<sup>351</sup>

Macvicar believed there were a number of benefits in African nurses, both to society as well as the young women themselves. One of the most obvious was the well-paid and respected job. Though it seemed to take quite a bit of convincing,<sup>352</sup>

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<sup>350</sup> ‘Victoria Hospital, Lovedale: Report for the Year 1935 Appendix’, *SAO* February 1936, 45.

<sup>351</sup> AMKWT 1671/SH 032/H/B. If the handwritten comment is correct regarding her position as ‘acting Matron’, however, this is probably the wrong date. Miss Gregory, formerly the Matron of Butterworth Hospital, was the acting matron while Mary Balmer was on furlough during much of 1915 (‘Victoria Hospital Report for 1915’, *CE*, February 1916, 31). Alternatively, if the date is more accurate, it may have been from some time around, or shortly after, 1919, when Miss E. Gregory came on the Victoria Hospital staff as a Sister (‘The Victoria Hospital, Lovedale. Report for 1919’, *CE*, February 1920, 28).

<sup>352</sup> For a brief account of the early and frustrating period of time after the first nurses had qualified, see Macvicar, ‘The Service of Native Hospital Nurses to Evangelism’, *SAO*, April 1936, 83. For



the eventual hiring of Lovedale-trained nurses and steady work with good pay proved the early pioneers correct in their desire for these trained professionals. It was probably also hoped that such respected roles in the communities would be an example to other women throughout the country.

Yet it was through an army of educated nurses that Macvicar hoped to achieve his greatest goal: upending the African system of thought regarding witchcraft and other 'superstitions' ideas on the subject of sickness, disease, and death.<sup>353</sup> His early articles, including Victoria Hospital reports, are spotted with this specific aim as a primary reason for training the nurses.<sup>354</sup> This view on the importance of and great hope for African nurses was heartily shared by at least some others in the South African medical community.

They [the African nurses training at Victoria Hospital] give promise of becoming efficient and useful among their people both as an educative agency and in times of sickness. It is difficult to conceive of anything which will strike so surely at the roots of witchcraft and other foolish superstitions as will this training.<sup>355</sup>

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issues of dissatisfaction among white nurses on female African nurses and African male patients, see 'The Training of Native Nurses', *CE*, February 1907, 30. Macvicar was also concerned that the most capable young women for the profession were going into teaching rather than nursing, commenting that it would probably take some time before the most apt would finally see the sense in becoming nurses: Macvicar, 'The Question of the Nursing of Natives in South African Hospitals,' *CE*, January 1907, 10–11.

<sup>353</sup> Such aims were echoed in later nurse and medical assistant training within southern Africa. See, P.H.J. Lerrigo, 'An African Medical Staff' *IRM* 17 (1928): 197-204; Kumwenda, 'African Medical Personnel', in *Healing Bodies, Saving Souls*, 210.

<sup>354</sup> See, for example, Macvicar, 'The Victoria Hospital, Lovedale', *CE*, October 1906, 208; Macvicar, 'Medical Missions in South Africa', *CE*, February 1904, 18.

<sup>355</sup> *South African Medical Record*, quoted in *CE*, December 1904, 180. This portion was taken from a half-page long quote in 'The Christian Express' with very little introduction. The rest of the quoted portion of the article dealt with nursing issues in varying parts of South Africa.



Dr Macvicar and staff. The accompanying text on the photo reads: "Staff +/- 1920", and "Dr Neil Macvicar and Matron Mary Balmer with the black nursing staff around 1920". It seems more likely that this photo is from circa 1925, shortly before Matron Balmer's retirement in 1926.<sup>356</sup>

Nearing the time of his retirement, Macvicar continued espousing the same theme he had advocated in his early years at Lovedale. In a section of an article on 'Native nurses', entitled 'Combating Superstition', he encapsulates much of his thought on the matter:

Women who can deal intelligently and authoritatively with witchcraft and other superstitious ideas of disease are a new thing in Native society. Other educated Natives may personally disbelieve – many of them do – but when it comes to giving their reasons they lack data. Only doctors and well-trained nurses have the facts at their finger tips. And, as is well known, the belief in witchcraft as a cause of disease is one of the grossest and cruellest things in heathenism. Apart from what they each can do to mitigate suffering and save life, the

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<sup>356</sup> AMKWT 1657/SH 032/H/B.

service Native nurses render to their people in the way of enlightenment is of first-class importance. The influence of trained nurses is out of all proportion to their numbers.<sup>357</sup>

Nurses were not, however, the only African medical trainees at Victoria Hospital. At the same time, Macvicar had begun instructing hospital assistants.<sup>358</sup> Though he had only been at Lovedale for seven and a half weeks, Macvicar remarked in his first (1903) Victoria Hospital report that a number of young men approached him for information about apprenticeships at the hospital.<sup>359</sup> By August of that same year, three men had begun their three-year long training as hospital assistants.<sup>360</sup> While not on scale with Western doctors, as he believed this was far beyond their present reach (and would probably remain so for the near future), these African assistants were to occupy a secondary tier in medical work.<sup>361</sup> On completion of their training, it was hoped that many of them would be able to go out into the rural districts as dispensers, able to treat minor ailments as well as to direct more severe cases to hospitals. And in Macvicar's desire to impact the wider populace, these junior medical men would help bring Western 'scientific truth' to the minds of the Africans. Macvicar believed this plan brought a number of benefits to all involved: the hospital assistants themselves, as already seen with the nurses, would

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<sup>357</sup> Macvicar, 'Victoria Hospital, Lovedale: Report for the Year 1935 – Appendix', *SAO*, February 1936, 43.

<sup>358</sup> Note that Macvicar began training African hospital assistants during his time at Blantyre, 1896–1900, and apparently even published a small book, *Lectures to Hospital Assistants* (Domasi Mission Press, 1898). For more on this subject, see chapter 6, as well as, Shepherd, *A South African Medical Pioneer*, 33–59.

<sup>359</sup> Macvicar, 'Victoria Hospital', *CE*, January 1903, 7.

<sup>360</sup> *CE*, September 1903, 132.

<sup>361</sup> Macvicar, 'The Question of a Medical Training for Natives of South Africa', *The Lancet* (23 September 1905): 909-910. He goes on to present his suggested course for what could be called medical assistants – probably either the very course he had been running or something similar to it. See also the very interesting article that not simply comments on, but takes issue with, Macvicar's claims regarding the readiness of the African. It seems, in a sense, a reversal of the typical points of view: 'Medical Education in South Africa', *The Lancet* (23 September 1905): 901-903.

be able to receive a thorough education and well-paid jobs; the people, who would otherwise be very hard-pressed to see a European doctor, would receive Western medical treatment; and there would be the opportunity for the trained assistants to disseminate medical knowledge, teaching their countrymen about bacteria, personal hygiene, preventative health care and the causes of illness.

Though these men were being trained up for similar reasons as nurses, the Victoria Hospital/Lovedale system was deeply flawed, with the programme never becoming well established.<sup>362</sup> Years afterward, Macvicar stated that all three attempts at even more thorough medical training for African men within South Africa (Victoria Hospital/Lovedale, the American Mission in Natal, and the Union Government at Fort Hare) had been either unsuccessful (Lovedale and the American Mission) or under a process of radical revision at the time of his writing (Fort Hare).<sup>363</sup> He reasoned that the breakdowns came about, when compared with relatively successful efforts in Central Africa, because of the greater number of diseases endemic to South Africa, the higher (European) standards for workers in South Africa, and the number of European doctors practising their trade.<sup>364</sup> On closer examination, one cannot help but see that problems within the school itself were exacerbated by the largely indolent attitudes of missionary and Christian

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<sup>362</sup> Macvicar mentioned the continuing presence of hospital assistants and orderlies in his Victoria Hospital Annual reports up until 1916 (it may have continued into the following year; however, I was unable to obtain records from 1917), but even at this time there was but one young man to have completed his training, compared with five nurses having completed nursing training and seven in the programme: 'Victoria Hospital, Lovedale: Report for 1915', *CE*, February 1916, 31. This may be due to a variety of reasons: the newly established South African Native College at Fort Hare; Health Classes that Macvicar had been teaching which students may have taken along with a route toward teaching; the First World War and related disruptions.

<sup>363</sup> McCord, with Douglas, *My Patients Were Zulus*, 230–240.

<sup>364</sup> Macvicar, 'Hospital Training in Tropical Africa', *SAO*, April 1942, 74.

circles, provincial and federal governmental racist policies and lethargy for positive change, and wider white societal attitudes which were prejudiced against black African medical personnel.<sup>365</sup>

Though there was a mixed long-term success rate in the training of African nurses and hospital assistants, Macvicar did not stop there in his quest to educate influential leaders on matters of health, healing, and disease from a Western perspective. From 1909 to 1919, he taught science and health-related courses to senior Lovedale students – both future teachers and others.<sup>366</sup> Through this medium, Macvicar extended the scope of his influence far beyond that of nurses and dispensers. With these teachers going out into village schools, he reasoned that not only would more areas be reached, through a highly respected member of the community, but that they would be teaching the children scientifically based understandings of preventative health care.

In addition, it was at the instigation of many of these Lovedale students that Macvicar helped them start ‘The South African (Native and Coloured) Health Society’, whose stated goal was the ‘promotion of health among the Native and Coloured People of South Africa’. This Health Society sought to enact change through a variety of methods, primarily educational, as well as to influence the South African government.<sup>367</sup> Within just a few years of its inception, the South African Health Society published nearly ninety thousand pamphlets and reading material on health matters, in southern African languages (i.e. Xhosa, Zulu, Sotho, English,

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<sup>365</sup> B.K. Murray, ‘Black Admissions to the University of the Witwatersrand, 1922–1939’, *South African Historical Journal*, 14 (November 1982), 35–53.

<sup>366</sup> Shepherd, *A South African Medical Pioneer*, 123.

Afrikaans, and Tswana), such as *How Consumption Spreads in Families*, *The Prevention of Consumption*, *Public Health Administration under Union*, *Facts About Alcohol*, *Communicable Diseases among Coloured Servants*, *The Consumption Catechism*, *Advertised Medicines*, and an Anti-Tuberculosis calendar.<sup>368</sup> Rather than restricting the spread of this health propaganda to missionary societies or churches, the Health Society worked to advertise and disseminate their information widely, including through state and local governments, labour associations, mining companies, as well as social organisations.<sup>369</sup> This manner of public health education demonstrates a policy in mission medicine in which the recipient community was far greater than simply targeting the smaller pre-existing Christian community.

#### *Mass Education*

While Macvicar's main effort in educating those beyond the confines of Lovedale centred on published material, this was not his only effort. He also advocated more widespread health teaching in schools throughout South Africa, as had been going on in other countries and territories, such as Great Britain, America, and other British Colonies and Protectorates. He argued that widespread standard health courses would (and should) inform the children of advances in scientific thought as well as the basics of personal hygiene and the spread of disease.<sup>370</sup> Such

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<sup>367</sup> Macvicar, 'Letter to the Editor', *CE*, June 1910, 106.

<sup>368</sup> 'South African (Native and Coloured) Health Society', *CE*, June 1912, 87; 'Letter to the Editor – The Native Health Society', *CE*, October 1913, 157-158.

<sup>369</sup> Macvicar, 'The Health Society', *SOA*, July 1929, 131-132.

<sup>370</sup> Macvicar, 'Health Teaching in Schools – With Special Reference to Native Schools – I', *CE*, September 1908, 143-45; 'Health Teaching in Schools – II – With Special Reference to Native

elementary education, he hoped, would provide a means of upending ‘superstitious’ ideas regarding the origin and transference of disease among the future generations, ensuring a long-term change in worldview. An extended quote, from 1910, allows the reader to capture more fully his thinking on the subject:

Among whites, as well as natives, popular conceptions regarding the human body and the diseases to which it is subject are often entirely erroneous. There is not merely ignorance, there is positive misconception. Witchcraft is still the foundation idea in the Natives’ theory of disease, and anything more contrary to reason, anything more able to stir up hatred and provoke un-Christian action it would be hard to imagine. Many Europeans also, even educated men and women, are misled by strange and erroneous ideas on the subject of disease. Further it is a fact that in some cases Europeans living all their lives among Natives, unconsciously adopt their superstitions. The study of Nature and its unvarying laws, together with teaching directed to show the real nature of disease, would be at least an attempt to combat this evil and subtle influence. There is nothing in the present school course that serves this purpose, and were it for no other reason than this Health teaching would be justified in the interests of truth and of sound education.<sup>371</sup>

He furthered this, by trying to provide teachers with ready access to practical health information through the diffusion of the Health Society Magazine.<sup>372</sup>

As well as his calls for the instruction of health courses in schools,<sup>373</sup>

Macvicar was active in publishing literature regarding a whole host of health-related issues. The majority were intended for public consumption (albeit the literate public). One book which he co-authored, *The Book of Health*, was designed for school children and teachers in Botswana (then Bechuanaland), though it was recommended, in the foreword, that teachers reach out to adults in their communities

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Schools’, *CE*, October 1908, 165–66; ‘Health Teaching in Schools – III – With Special Reference to Native Schools’, *CE*, November 1908, 177–78.

<sup>371</sup> While not explicitly accorded to Macvicar at the end of this article, I have very little doubt that he authored it. ‘The Argument for Health-Teaching in Schools’, *CE*, August 1908, 118. Schooling, of course, did not affect the majority of black South Africans during this time, especially in higher levels of education.

<sup>372</sup> Macvicar, ‘The Native Health Society’, *SAO*, July 1929, 133.

<sup>373</sup> Shepherd noted that Physiology and Hygiene were brought into the Cape Education Department’s syllabus in 1919: *A South African Medical Pioneer*, 123. Though he doesn’t accord this to Macvicar’s influence and it would be too far reaching to assume it was due entirely to this, I believe Macvicar’s voice played a significant role in its establishment.

and perhaps go through the book with them.<sup>374</sup> This particular book covered subjects as widely varied as ‘The Human Body’, ‘Environment’, ‘Food’, ‘Communicable Diseases’, and ‘First Aid in Accidents’. Additionally, his popular pamphlets, *Food* and *The People’s Food*, as well as the book, *What to Eat and Why*, all addressed the subject of nutrition, a health issue of vital importance, though made even more difficult to correct because of the extreme poverty among the majority of the black South African population.<sup>375</sup>

While publications such as these were not written explicitly to counter belief in witchcraft, for instance, this was an indirect effect. From his point of view, nutritive deficiency diseases like Beri-beri or Pellagra could have been easily misdiagnosed and mistreated by African traditional healers. Consequently, he viewed his mission as a quest to provide vast amounts of information on health-care issues, in order to avoid situations which might otherwise lead an ill person to seek the assistance of a traditional doctor. He wanted to provide scientifically based knowledge to the wider public, even though the people were not necessarily looking to learn about the matters on which he wrote.

Whether in training a highly educated class of African nurses, hospital orderlies and teachers, or writing health-care related books and pamphlets for public use, Macvicar worked to upend traditional beliefs. He then laboured to implant Western-based medical and scientific ideas regarding the cause and spread of disease

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<sup>374</sup> Neil Macvicar and Peter M. Shepherd, *The Book of Health* (Lovedale: The Lovedale Press, 1948), 105. Peter Shepherd, a United Free Church missionary in Botswana, was the brother of the Lovedale Principal, Robert Shepherd.

<sup>375</sup> Macvicar, *Food* (Johannesburg: S.A. Institute of Race Relations, 1942); *The People’s Food: Recent Discoveries and their Application in South Africa* (Johannesburg: S.A. Institute of Race



as well as aspects of healing and renewed health. While speaking about the role of hospitals, and the duty of the South African government to produce increased access for the black population, Macvicar summed up his point with words that recapitulate much of his work on this overarching issue: ‘Superstitions about the cause of disease will not disappear spontaneously; they have to be combated and true ideas put in their place.’<sup>376</sup> Those ‘true ideas’ for Macvicar rested heavily on Western biomedical and scientific fundamentals. Yet these foundations affected not only his response to African belief about healing and the cause of illness, but his own outlook on Christianity and the supernatural.

### **Macvicar’s Belief Structure**

While much has been discussed regarding Macvicar’s personal understanding of African belief in ‘superstitious’ ideas regarding disease – witchcraft, spiritual entities, supernatural forces – and his efforts to displace and supplant them with a more standard Western-informed scientific knowledge, it is worthwhile briefly to examine Macvicar’s own belief structure. His disbelief in supernatural elements affecting and intermingling with the natural order was not restricted to traditional African beliefs; his personal Christian theological outlook did not allow for such ideas either. In this way, Macvicar stood apart from many of his fellow missionaries,

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Relations, 1946); *What to Eat and Why* (Lovedale: The Lovedale Press, 1943); ‘Meals for School Children’, *SAO*, October 1943, 136.

<sup>376</sup> N. Macvicar, D. Ryan and H.M. Bennett, *Native Health* (Lovedale: The Lovedale Press, 1940), 4.

who came out of the more evangelical strands of British and American Christianity so common among the missionary societies.

*An 'Unorthodox' Medical Missionary*

One of the very few sources for gaining insight on Macvicar's belief structure, from his own pen, comes from Shepherd's biography of his friend. In Shepherd's chapter on his subject's 'Edinburgh University Days' an intriguing report is recounted about a meeting that Macvicar had, along with fellow student and friend, Matthew Wilson, with the renowned adventurer H.M. Stanley one evening in December 1893. As both young men were over halfway through their medical studies, they were beginning to pursue openings for medical missionary work in Africa but found that their personal religious beliefs were making their endeavour quite difficult. Macvicar's personal diary entry from the night of their meeting related, to the best of his ability, their encounter. It reveals, in a most personal way, part of his journey and thoughts at that time.

Upon receiving them in his Edinburgh hotel room, Stanley enquired about their purpose for meeting. In response, Macvicar said that they wanted to know if he knew of any companies or societies doing work in Africa that might be willing to take on able young medical men. They seemed to be proving themselves too unorthodox for the mission societies they had contacted; and the companies they had been in touch with were simply unresponsive. An extended quotation of Macvicar's account of the conversation is especially insightful. Beginning with an answer to Stanley's question about whether they had checked with Grattan Guinness's Mission in the Congo, Macvicar wrote:

N.M.: Ah, they are terribly orthodox. We would have no chance there. When I was in London last Summer I called on what was called an undenominational Mission – the Zambesi Industrial Mission and the Secretary told me I needed a missionary to myself and that I was quite unfitted to be a missionary.

Stanley: How?

N.M.: He said that, when I told him I did not believe in the verbal inspiration of the Bible.

Stanley: Ah, well, there's the Church Mission Society and the Baptists and the London Mission Society and the Roman Catholics. But what is your difficulty?

N.M.: Well, we feel that we should like to give our lives to Africa but we don't feel able to sign the Confession of Faith or anything of that sort. In fact we wish to carry out the teaching of Christ so far as we understand it.

Stanley: But do they require a Doctor to sign the Confession of Faith?

N.M.: No, I should have said that. But they require a Dr. to believe a great part of it or they won't send him out.

PAUSE.<sup>377</sup>

While the advice may have come from one of the more revered explorers of their day, Stanley's recommendation that they depart for Africa on their own initiative and retain work once they arrived was not heeded by Macvicar. More important for this study than Stanley's advice to young men, however, was the candour and frankness of Macvicar's position on theological matters. His diary entry, limited though it is, reveals a portion of his independent spirit and specific dissatisfaction with notions of a heavenly directed inspiration of Christian Scripture, yet also a strident desire to do his work in conjunction with a Christian mission organisation. In this respect, he is almost reminiscent of a figure like Bishop John William Colenso, the first Anglican Bishop of Natal, in South Africa. While Colenso was not an explicit missionary, his mid-19<sup>th</sup> century career in South Africa is notable for the controversy created through his biblical criticism. A strong belief in the influence of then modern scientific knowledge to shape theological understanding led him, at one point, to upend the

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<sup>377</sup> Neil Macvicar, quoted in Shepherd, *A South African Medical Pioneer*, Lovedale: The Lovedale Press, 1952, 17.

traditional views on portions of the Old Testament and expose textual inconsistencies (aided especially with the utilization of his mathematical skills).<sup>378</sup> Though Macvicar did not identify the particular portion of the Confession that he disagreed with, his positions on some fundamental matters of the faith were to become unveiled after he offered himself for medical missionary service to his home church.

The first records from the Church of Scotland Foreign Mission Committee Letter Book which mention Macvicar show, unsurprisingly, no sign of the turmoil that was to come in the months thereafter. The Rev Dr Archibald Scott, minister at that time of St George's, Edinburgh, and a member of the Africa Sub-Committee, in a letter to Alexander Hetherwick (of the Blantyre Mission) mentioned that he had heard Macvicar was eager to head off for Africa, if only his health would allow.<sup>379</sup> In the following few months Macvicar's health was not the only concern as he had committed to an internship at the Royal Infirmary (Edinburgh) with Professor William Greenfield and both the Committee and he were faced with the quandary of whether or not to break free from the obligation.<sup>380</sup> Though they were anxious to

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<sup>378</sup> See, for example, John William Colenso, *The Pentateuch and Book of Joshua Critically Examined* (London: Longman, Green, Longman, Roberts, & Green, 1862), passim.

<sup>379</sup> Archibald Scott, Edinburgh, to Alexander Hetherwick, Blantyre, British Central Africa, 14 January 1895, MS 7535, CS Foreign Mission Committee Letter Book, NLS, 139.

<sup>380</sup> John McMurtrie, Edinburgh, to Professor W.S. Greenfield, Edinburgh, 30 April 1895, MS 7535, CS Foreign Mission Committee Letter Book, NLS, 238-239.

have a medical missionary placed at Blantyre,<sup>381</sup> they finally decided it was in the long term interest of all involved that Macvicar complete his term at the hospital.<sup>382</sup>

Macvicar's theological 'problems', in the eyes of the Committee, began to come to light in the spring of 1895 and there were varying opinions about the decision to send him out. In a portion of a letter to Hetherwick, Archibald Scott related the trouble:

Complications which may be serious have arisen in connection with the appointment of Dr Macvicar. Professionally and in respect of disposition and character he is all we can desire, but a member of the Foreign Mission Committee has challenged his orthodoxy, and upon conferring with him we have discovered that in respect of the Resurrection, Ascension and Divinity of our Lord, he is Unitarian. Personally I believe in his sincere desire to be led into the truth and I regard him as a case of faith immature which very probably would increase with service of Christ, but such as it is we could not venture to send him out in the name of the Church... [though] I am strongly inclined to risk him.<sup>383</sup>

McMurtrie (Chair of the Church of Scotland Foreign Mission Committee), in a letter to Hetherwick one month later, offered his own perspective. "I weary for a letter from Dr Neil Macvicar. I gave him Liddon on our Lord's Divinity to read. He has not studied the subjects on which he has difficulties, but has just fought away in his own mind, and got among a set of semi-religious half-believers."<sup>384</sup> Though

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<sup>381</sup> There had apparently been rather vehemently expressed rejections by Hetherwick of some of the candidates for medical missionary, one of which he apparently did not like due, at least in part, to the candidate's time and training at the Edinburgh Medical Missionary Society's Cowgate Mission. This, most understandably, rankled McMurtrie who was actually a Director on that Society's Board. See McMurtrie to Hetherwick, Domasi, BCA, 20 October, 1894, MS 7535, CS Foreign Mission Committee Letter Book, NLS, 71.

<sup>382</sup> McMurtrie to Greenfield, 20 June 1895, MS 7535, CS Foreign Mission Committee Letter Book, NLS, 310. By this time, the British Administration in BCA had posted a doctor to Blantyre for a temporary spell.

<sup>383</sup> Scott to Hetherwick, 15 July 1895, MS 7535, CS Foreign Mission Committee Letter Book, NLS, 353-354.

<sup>384</sup> McMurtrie to Hetherwick, 16 August 1895, MS 7535, CS Foreign Mission Committee Letter Book, NLS, 387. For the book which McMurtrie refers to see, H.P. Liddon, *The Divinity of Our Lord and Saviour Jesus Christ, Eight Lectures Preached before the University of Oxford in the Year 1866*, Sixteenth Edition, (London: Longmans, Green, and Co., 1892).

Macvicar had strong detractors, including his own father,<sup>385</sup> he had McMurtrie, Archibald Scott and the Blantyre missionaries, Rev D.C. Scott (of Blantyre) and Hetherwick, among his backers. In the end, the Committee decided, in October 1895, to appoint him as the Medical Officer of the Blantyre mission, expressly not as a missionary.<sup>386</sup> While it had been planned that he would immediately leave for the mission, Macvicar's health took a poor turn and his departure was, for a time questionable, though only delayed a few months.<sup>387</sup> By January of 1896, Macvicar set off for central Africa.

While at Blantyre, Macvicar enjoyed fresh fields of study, met and married his wife, and not only oversaw the construction of a new hospital, but also began training some young African men in medical practice.<sup>388</sup> Some of these, however, proved to be strenuous situations with the Foreign Mission Committee. Cost overruns on the hospital and the issue of whether his wife, Jessie Macvicar (nee

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<sup>385</sup> Peter Macvicar, Neil's father, was a Church of Scotland minister in the small hamlet of Manor, outside of Peebles, in the Scottish Borders, where Neil grew up. He apparently wrote either to the Foreign Mission Committee, or perhaps personally to McMurtrie, to express his strong reservation about Neil's possible appointment as a missionary, owing to his theological beliefs. For McMurtrie's response to the letter, see McMurtrie to Peter Macvicar, Peebles, 18 October 1895, MS 7535, CS Foreign Mission Committee Letter Book, NLS, 453-454.

<sup>386</sup> Archibald Scott to Hetherwick, 24 October 1895, MS 7535, CS Foreign Mission Committee Letter Book, NLS, 470.

<sup>387</sup> For information on Macvicar's bout of influenza see the letter to his sister, John McMurtrie, Edinburgh, to Jean Macvicar, Edinburgh, 28 October 1895, CS Foreign Mission Committee Letter Book, NLS, 489. A month later, his health must not have been considerably better and the sentiment expressed about him by Archibald Scott is notable in its own right: "Before this Dr H. Scott will have told you that Dr Macvicar cannot leave this country for some months to come – indeed it is quite possible that he may not leave it at all: for his constitution seems particularly susceptible to disease. I am very concerned about him – for he is not only a good young man, but a Medical Genius. It may all come right yet." A. Scott to Hetherwick, Blantyre, 20 November 1895, CS Foreign Mission Committee Letter Book, NLS, 539.

<sup>388</sup> Archibald Scott was especially impressed with Macvicar's work in the area of training Africans and was extremely supportive of his labour, effort, and the long term impact. See Scott to Macvicar, 28 September 1898, 1 October 1898, MS 7536 CS Foreign Mission Committee Letter Book, NLS, 976-977, 980. For discussion on the training and education Macvicar provided at Blantyre see chapter 5 of this thesis; chapter 4 for interest on indigenous plants and traditional uses.

Samuels), would continue as a paid missionary proved to be contentious matters between the two sides. Although these matters may have contributed to some sense of unease among some in Edinburgh or with his fellow missionaries at Blantyre, they have been discussed in other work on the subject,<sup>389</sup> and need not be covered in detail here.<sup>390</sup> Of greater importance for this study are the revelations about Macvicar's theology and belief structure concurrent with this time.

As with the recollection of the meeting with H.M. Stanley, Shepherd's biography once again provides the historian with transcripts of Macvicar's writings (material that seems to be otherwise lost). In response to a letter from McMurtrie,<sup>391</sup> a portion of which centred on the question of Macvicar's ability to assent to 'orthodox' Christian belief, and thereby become a full-fledged medical missionary of the Church of Scotland, Macvicar replied with openness,

With reference to your question as to the possibility of my becoming a Medical Missionary, I cannot conscientiously say that I can express any more decided convictions upon such questions as the doctrine of the Trinity or the Resurrection than I did at the time of my appointment. I know that my beliefs are shifting sandbanks under the water, but they have not set solidly or appeared above the surface, so that I could give you a map of them or even reliable soundings.<sup>392</sup>

Macvicar seems to have held deep reservations about the role and person of Jesus, something that unnerved many involved with the Church of Scotland's missionary activity. Although these few lines do not encompass what he actually *did* believe,

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<sup>389</sup> See Shepherd, *A South African Medical Pioneer*, 32-63; Andrew C. Ross, *Blantyre Mission and the Making of Modern Malawi* (Bonn: Verlag fur Kultur und Wissenschaft, 1996), 169-171.

<sup>390</sup> For letters from both Archibald Scott and John McMurtrie to Macvicar regarding the hospital cost overruns see MS 7536, CS Foreign Mission Committee Letter Book, NLS, 200-201, 318-319, 389-390, 638-642, 648, 686, 790-791, 867; regarding the salary issue see 820, 920.

<sup>391</sup> McMurtrie, Edinburgh, to Macvicar, Blantyre, 12 November 1897, MS 7536, CS Foreign Mission Committee Letter Book, NLS, 648.

<sup>392</sup> Neil Macvicar, Blantyre, to John McMurtrie, Edinburgh, 6 January 1898, quoted in Shepherd, *A South African Medical Pioneer*, 63-64.

they, along with earlier insights, begin to reveal the sceptical side of Macvicar that clung more heartily to truths that he could either scientifically examine or give rational assent to. The centrality of Jesus Christ – who he was, what he said and meant, issues of his divinity, and what he did – as well as issues of Natural Theology, and God’s activity within the natural order were some of the more intriguing and intense areas of discussion during this period in late 19<sup>th</sup> and early 20<sup>th</sup> century Christian history.<sup>393</sup>

In what appears to come from some point during his time in Edinburgh (c.1901), between the beginning of his furlough (and subsequent dismissal) from Blantyre and before beginning his work at Lovedale, Macvicar wrote a one page summary of his personal belief. This small text, in his own words, reveals not simply what others record about him, but is especially insightful by its demonstration of what he emphasised in his own theological outlook. It does not seem unreasonable to conclude that it was written both for himself as well as anyone who that may have asked about his theological beliefs. It is, in essence, a demarcation of what he felt he could freely ascribe to, and is notable for the areas of Christian belief that he stresses. Penned when he was about thirty years old, and going through a major transition in life, it is especially apt to quote the whole piece.

I believe that God, the Eternal and Almighty Creator and Sustainer of all things, is our Father and the Father of all men. By this I mean that He is a Person; that He has brought us into being, persons as we are and conscious as we can be not only of ourselves as free units but also of our relationship to Him, and that He takes a loving care of each one of us. When I say He is a Person, I mean that though He is no doubt far more than the word conveys to any human mind, yet the thought is true

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<sup>393</sup> See, for example, discussion in Edinburgh during Macvicar’s University days, Otto Pfeleiderer, *Philosophy and Development of Religion: Being the Gifford Lectures delivered before the University of Edinburgh* (Edinburgh: W. Blackwood, 1894); Rainy, Orr, and Dods, *The Supernatural in Christianity: With Special Reference to Statements in the recent Gifford Lectures*, (Edinburgh T.&T. Clark, 1894).



and the more we are able to realise the meaning of the idea of free personality the more will we be right in applying the name to God.

How a Being of such vast power and unthinkable grandeur can yet deal individually with each one of us is to me no serious difficulty. This difficulty seems to me to be due to a too timid grasp of the idea of God's grandeur – for mere extent whether in time or space were a poor grandeur unless it were accompanied by a perfect knowledge of, and a power over every minutest unit of existence. And further, this difficulty is impossible to anyone who has leaned upon God and found support in every emergency. I believe that sonship of God is the birthright of every human being and that conscious sonship is possible to every human being. It is because I value so highly this incomparable privilege that I am an enthusiast for Missions.<sup>394</sup>

Macvicar's emphasis in this work, which he entitled, *A Credo*, emphasised the theme of the Fatherhood of God and a sense of the personal interaction between Him and mankind, rather than the divinity of Jesus. His work especially centred on the Person of God, and how this sense of Personhood or 'personality' has been replicated in individuals, thereby stressing the importance of the shared humanity amongst all people. Such sentiments strike a notable theological tone when taken further into notions about race and shared humanity amongst all races, and thereby more akin to late 18<sup>th</sup> and early 19<sup>th</sup> century Scottish Protestant thinking, as Andrew Ross has insightfully pointed out.<sup>395</sup>

Of additional importance in Macvicar's theological belief is the idea of God's innate and available intimacy with each person. In this regard, Macvicar stands in direct contrast to some Theists and Deists of his day who may have shared with him the emphasis for emerging scientific discoveries and theories to greatly impact their

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<sup>394</sup> Macvicar, quoted in Shepherd, *A South African Medical Pioneer*, 64-65. Since Shepherd notes that Macvicar wrote this at thirty years of age, it would correspond with anywhere from August 1901 to 1902. This is exactly the time period when he would probably have been trying to clarify his own beliefs, both to himself as well as others, especially after having been dismissed from Blantyre, rejected for the Church of Scotland's East Africa Mission, and beginning talks with Rev. James Stewart for work at Lovedale (Spring - Summer 1902).

<sup>395</sup> Andrew C. Ross, 'Christian Missions and the Mid-Nineteenth-Century Change in Attitudes to Race: The African Experience', in Andrew Porter, ed., *The Imperial Horizons of British Protestant Missions, 1880-1914*, (Grand Rapids: William B. Eerdmans Publishing Company, 2003), 86-87.

Christian belief structure. For in fact, Macvicar leans upon one of the more deeply held aspects of Western scientific theory: the experimental testing of a theory/belief. In this case, his contention is that God's grandeur – in essence, the greatness of His being whereby He is able to be called God – is in fact so great that He can relate to all of those who are conscious of Him in a personal way; supporting (or 'testing') this view with personal experience.<sup>396</sup> It is these two emphases, the Fatherhood of God and His intimacy with individuals, which are the most notable aspects of his expressed theology.

While it can be rather tenuous to make many conclusions from omissions, it seems entirely appropriate, given the background, to note at least one aspect Macvicar failed to incorporate in his statement of belief; the absence of either Jesus or the Holy Spirit, and hence a belief in the Trinity,<sup>397</sup> a theological opinion, or exclusion, which seems to have been the basis for his father failing to give his blessing to his son's appointment as a missionary of the Church of Scotland back in 1895.<sup>398</sup> Since he left out even the mention of Jesus, Macvicar does not allow room for much discussion on many of the issues his earlier examiners raised or commented on. Ironically, as we shall now see, it was the very subject of theological speculation which the Rev Dr James Stewart apparently warned Dr Macvicar to not get carried away with.

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<sup>396</sup> Macvicar, quoted in Shepherd, *A South African Medical Pioneer*, 65.

<sup>397</sup> Shepherd, *A South African Medical Pioneer*, 20.

<sup>398</sup> Though this topic is not explicitly mentioned in John McMurtrie's response to Rev. Peter Macvicar, this is probably the reason for certain phrases he uses: "You know that it is the soul that rests on a Divine Saviour through experience of His keeping power. Your son does not know that yet.... Even on the supposition that he does not draw nearer to Christ in two years..." McMurtrie, Edinburgh, to Rev. Peter Macvicar, Manor – Peebles, 18 October 1895, MS 7535, CS Foreign Mission Committee Letter Book, NLS, 454 [McMurtrie's emphasis].

*Medical Missionary of Lovedale*

After having been back in Scotland for nearly two years, dismissed from Blantyre and unable to secure a medical missionary post elsewhere in Africa in the mean time, Macvicar began serious talks with Stewart about a position at the Victoria Hospital, Lovedale.<sup>399</sup> Stewart had been back in Scotland for the previous few years; during this absence from Lovedale he held such distinguished posts as Moderator of the Free Church of Scotland, 1899-1900 (just prior to its merger with the United Presbyterian Church), as well as the Duff Missionary Lecturer at New College, University of Edinburgh, in 1902. Though the hospital had opened in 1898 and was run under the direction of Dr James McCash and Misses Wallace and Hawes,<sup>400</sup> it was closed during the Anglo-Boer War, owing to a lack of money.<sup>401</sup> On the 10<sup>th</sup> of July 1902 Macvicar again met with Stewart in Edinburgh to further discuss arrangements which would allow him to become the medical missionary at Lovedale and thus re-open the hospital. The following day Stewart wrote to Mr D.A. Hunter, the Lovedale volunteer missionary who was really the man responsible for the construction and long term success of the hospital, outlining four main subjects they discussed in their meeting.

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<sup>399</sup> For information regarding the history of Victoria Hospital or the medical missionary aspect of Lovedale see chapter 2.

<sup>400</sup> McCash was referred to as the Superintendent during his time, 1898-1900, as were Miss Wallace, 1897-1898, and Miss Hawes, 1899-1900 (Lady Superintendent, at one point). See the typed summary documents, *Lovedale Missionary Institution Staff, taken from the Lovedale Reports*, Amathole Museum, King William's Town, Lovedale Box, 2, 3a. In a small pamphlet addressed to children of the United Free Church of Scotland, James Stewart simply calls McCash the hospital doctor and Miss Hawes the chief nurse. See Rev. James Stewart, *Leaflet for the Children: Lovedale Native Hospital, South Africa*, No. 3. Edinburgh: United Free Church of Scotland, May 1901, 2.

<sup>401</sup> In his leaflet to the children, Stewart wrote: "We get very little money from this country. Last year the Boys' Brigade sent us £43; the Edinburgh Medical Missionary Society, £231; the Ladies' Committee, £20; and some other friends, £56. We need for the year three times as much – that is, £900....The native people paid £110 for medicines last year." Ibid, 4. The hospital was closed just

The only pertinent portion of that conversation for this section was what Stewart encapsulated (in a letter to a colleague) as, “Private opinions on Theological and religious subjects”. Stewart’s summary and remarks are indeed quite revealing, both for Macvicar and himself:

These I talked over with him again. I said it did not seem to me to be necessary to make so much of them; that most men had difficulties about the Resurrection and other points, and that I thought it was giving undue prominence to points that never could be settled in this life, to make so much ado about them. I asked him if he accepted the fact or truth of these points, and if so the form, or method, or process was not of any consequence. That did not belong to us; either to devise or to settle.<sup>402</sup>

Perhaps the most interesting aspect of this text is Stewart’s acceptance of Macvicar’s personal belief regarding the Resurrection. Rather than trying to convince Macvicar of the event’s veracity or insisting that he compromise his stance, Stewart seems to be quite open to his scepticism about the event itself, so long as Macvicar’s theology melded into the spirit of the Resurrection (or other related theological hurdles). Stewart’s insistence on belief in the deeper ‘truth of these points’ was not simply giving in to what may have been considered lax or even blatantly wrong theology. As is evident further along in the letter, Stewart was both encouraged with some of the more fundamental aspects of Macvicar’s theology as well as adamant that nothing contrary to orthodox belief would be preached or taught by Macvicar. After discussing some of the hospital and job related issues that the two sides had, Stewart pointed out to Hunter one of the major conclusions agreed to at this meeting.

He [Macvicar] also agrees as in No. 3, to teach nothing contrary to the recognised doctrines of the Church, and to conduct simple ward services. On the subject of the love of God, and in the forgiveness of sins, he seems perfectly clear; and I repeat

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four months later due to insufficient funds. See the three page typed document by D.A. Hunter, *The Victoria Hospital, Lovedale*, [circa 1908?] MS 16,457, CL, LC, 2.

<sup>402</sup> James Stewart, Edinburgh, to D.A. Hunter, Lovedale, 11 July 1902, MS 16,457, CL, LC, 2.

here, as I repeated to him, that I think he makes too much of certain speculative difficulties, and as I said to him, my sympathy, while it goes so far with him, stops at once when the forms of these changes in the future come to be questioned, or attempted to be settled. That is a useless and futile attempt, and is a matter that should not be introduced into a practical question of this kind.<sup>403</sup>

Stewart obviously felt that he was providing a fair deal for Macvicar and his non-traditional beliefs (at least in many of the missionary circles) while also obtaining a much needed and very well qualified medical superintendent for the doctor-less Victoria Hospital. After years of a floundering medical presence at Lovedale, abated only by the temporarily opened Victoria Hospital, Stewart surely must have desperately wanted the hospital open and running again, even if the new Superintendent's expressed theological leanings were liberal. However, not everyone was as understanding about Macvicar's theological views as Stewart.

Before meeting with the Foreign Mission Committee, Dr Stewart had hinted to Hunter that he would probably have trouble with the Committee's acceptance of Macvicar as a medical missionary, owing largely to some of his opinions on Christian dogma, though there were monetary considerations as well.<sup>404</sup> In his next letter to Hunter, Stewart confirmed his earlier prediction. The Africa Sub-Committee apparently met, and according to Stewart, "not very agreeable work" went on, in Stewart's opinion; one member of the committee voiced a lack of money for salary and "others were concerned about [Macvicar's] theological opinions."<sup>405</sup> When the meeting was finally over, however, a compromise had been reached. Although Stewart had hoped for the full £300 salary to be given, the Committee agreed to give a £150 grant to the Lovedale Board for medical services – the hiring of medical

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<sup>403</sup> Ibid., 3-4.

<sup>404</sup> Ibid., 4.

personnel under the latter's sanction.<sup>406</sup> This arrangement therefore allowed the UFCS Foreign Mission to support Lovedale's medical missionary work without having been explicitly responsible for either mandating Macvicar's theological contentions or blocking his appointment. The plan, early on in this arrangement, was to see Dr Macvicar making up the rest of his salary with a practice for the Europeans of the area around the town of Alice. However, within the time of a week or so, John Stephen, the dedicated financial backer of Scottish missions, strongly advised Stewart to scrap that plan. Stephen convincingly argued that such an arrangement may well bring the new medical missionary into conflict with the district surgeon (Dr Kelbe). Additionally, he believed that Macvicar had the right, as a medical missionary, to be on an equal footing with all the others the Church had appointed, regardless of whether or not he was directly paid by the UFCS Foreign Mission. To this end, Mr Stephen pledged to meet the gap for three years either through raising funds or giving it himself.<sup>407</sup> With the arrangements in order, Macvicar and his family sailed in late September 1902, for Lovedale, South Africa, the place he would continue working as a medical missionary for the following thirty-five years.

#### Summary of Early Beliefs

From the material we have regarding Dr Neil Macvicar's early thought we can begin to sketch a rough outline of his belief structure. On the testimony of others who interacted with him on the subject it seems that he was heavily influenced by the

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<sup>405</sup> James Stewart, Edinburgh, to D.A. Hunter, Lovedale, 14 August 1902, MS 16,457, CL, LC.

<sup>406</sup> Ibid.

<sup>407</sup> James Stewart, Edinburgh, to D.A. Hunter, Lovedale, 22 August 1902, MS 16,457, CL, LC, 1-2.

liberal or modern strain in late 19<sup>th</sup> century Western Christianity. A strong hesitance to submit to creedal statements that he either outrightly disagreed with, or was not certain about, brought mixed responses. Archibald Scott, the minister of St. George's in Edinburgh and a member of the Church of Scotland Foreign Mission Committee, viewed Macvicar as a Unitarian, which seems an accurate description. Though it is quite difficult to encapsulate precise Unitarian theology, Macvicar encompasses many of the common beliefs.<sup>408</sup> Through his denial of the acceptance of Jesus as part of the Godhead, and many of the accompanying events commonly connected with his divinity,<sup>409</sup> Macvicar underscores his anti-Trinitarian position. With a stress on gaining truth through advances in the fields of social and physical sciences, Macvicar joined with many in the modern or liberal wings of Western Christianity who highlighted themes such as the Fatherhood and love of God, an emphasis on progress and reason, and critical analysis of the Biblical text and its associated 'myths'.

While his expressions of theological belief were rather limited in his early years in missionary work, Macvicar expressed them more openly in his later years of life. It is to writings which he composed after his retirement from Lovedale to which this section of the chapter now turns; writings which express much more candidly, perhaps, the notions which he had long held on to, but which he felt he could not honestly disclose while in employment at the mission.

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<sup>408</sup> An aversion to creedal statements or formulas, observed by some within the Unitarian tradition, tends to complicate efforts to pin down precise belief amongst the larger group of adherents. Joseph Henry Allen, *Our Liberal Movement in Theology* (Cambridge: John Wilson & Son, 1882), 1-7, 114-117.

<sup>409</sup> For example, the Virgin Birth, Resurrection, and Ascension.

*'A Common Man'*

Though having been retired from his active medical missionary work at Lovedale for seven years, Macvicar was still authoring articles for *The South African Outlook* and other literary work. He was, for all intents and purposes, still carrying on his work – having put down his medical instruments, while retaining his pen. In November of 1944 he wrote to his good friend, Rev Dr Robert Shepherd, then Principal of Lovedale and long standing editor of *The South African Outlook*. Along with relaying a few of his personal interests of late and some news from Johannesburg, Macvicar broached the possibility of Shepherd publishing in the *Outlook* a short article by him on the subject of Christian belief in the South African churches. He hoped, if Shepherd printed it, that the piece would provide an external jolt to the system for the upcoming South African Christian Council of Churches meeting. For he felt they were not being honest intellectually or theologically in light of modern understandings and advances in knowledge.<sup>410</sup> However, he knew, that his views would not necessarily be warmly welcomed, and just as he predicted, it was an article that provoked a stir amongst readers.<sup>411</sup>

When it was all said and done, 'The Churches of Today Looked At,'<sup>412</sup> was responsible for a number of letters to the editor, relatively speaking – most were agitated about the content, some also angry at the *Outlook* for printing it, and one that

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<sup>410</sup> Neil Macvicar, Johannesburg, to Robert Shepherd, Lovedale, 6 November 1944, MS 14,713(h), CL, LC.

<sup>411</sup> Macvicar's foremost concern was not about public opinion against himself, even though it first appeared under the authorship of 'By a Common Man'. His greatest fear was that Shepherd's reputation would become damaged – a trepidation expressed many times. His main reason for not assigning his own name (or the common practice of his initials, N.M.) was that he feared it would damage the good that was accomplished by his other writings under such authorship. For evidence of his concern for Shepherd, see the afore cited letter and Macvicar, Johannesburg, to Robert Shepherd, Lovedale, 15 November 1944, MS 14,713(h), CL, LC, among others.



was pleased with its appearance.<sup>413</sup> While most of these letters did not doubt the author's sincerity, they took issue with what was perceived as an assault on some basic Christian beliefs – and that those who believed them had not considered them with a rational or truth-seeking viewpoint. These dissenters, of course, raised their own points with reference to biblical commentaries, particular word study/exegesis, and various scholarly writings.<sup>414</sup> What was it that Macvicar wrote or meant that caused such a fuss?

Macvicar's goal in getting the paper published was to prompt a more honest and inquisitive examination of theological and biblical matters and in so doing he expressed not only some aspects of his own belief, but how he formed such ideas. In the same way that he derided much of the African traditional worldview as being held over from earlier ages (pre-Enlightened), he was convinced that many Christian leaders continued to espouse pre-modern belief. He confronted this with rather stark words:

One wonders whether religious leaders generally realise to-day how far in the minds of many people much of their message is becoming a mere fairy tale, and that the fault lies not entirely with the people but largely with themselves. Few of these leaders have had the courage in public to cut away from the biblical teaching of the past its exuberant growth of childishness, and to bring to the people in clear and understandable words the significance for our own day and for the future, of the books of the Old and New Testament.<sup>415</sup>

He went on to support this statement with examples from the New and Old Testaments. In his citation of the Jonah story, Macvicar hoped that the themes of the

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<sup>412</sup> Neil Macvicar, 'The Churches of Today Looked At', *SAO*, December 1944, 163.

<sup>413</sup> For a defender of the article and its publication, see M.M. Bogle, in 'Our Readers' Views', *SAO*, February 1945, 32; M.M. Bogle, Elliotdale, Cape Province, to [Robert Shepherd] The Editor of *SAO*, Lovedale, 7 March 1945, MS 14,713(h), CL, LC.

<sup>414</sup> H.P. Bull, in 'Our Readers' Views', *SAO*, January 1945, 15; P. Macpherson, in 'Our Readers' Views', *SAO*, January 1945, 15-16; A.P. Moore-Anderson, in 'Our Readers' Views', *SAO*, February 1945, 31-32; C.E.G. Goodall, in 'Our Readers' Views', *SAO*, March 1945, 43-45; H.P. Bull, in 'Our Readers' Views', *SAO*, March 1945, 45-46.

book – “its rebuke to race hatred and its glimpse into the heart of the Eternal” – would replace the more common rendering with, “the literary embellishments common to the period,” being taken as true.<sup>416</sup> His New Testament example focussed on the virgin birth of Jesus, something that, “To the common man reading the gospels and thinking about what he reads it appears tolerably evident that the story of the virgin birth is the result of the mixing up of a Greek myth with the gospel story. This mixing must have happened very early.”<sup>417</sup>

Whilst Macvicar believed that such simplistic readings of the virgin birth had led to dire conclusions throughout history, such as worship of the Virgin Mary and a “repudiation of the whole divine creative process”,<sup>418</sup> more importantly, he was convinced that they were fundamentally false. Hence, since churches and churchmen were still expounding false and ‘superstitious’ beliefs, they had lost their rightful place as the models and promoters of moral authority. The central Christian message, in Macvicar’s opinion, could really only be attained through critical analysis of the Scriptures. And after this had been sifted away from the false attachments of unenlightened times, the vital themes, morals, knowledge, and ethic could then be expressed and championed by the church:

... Ecclesiastical differences must be given their proper place on the shelf of history, and doubtful elements, often so intimately mixed up with the serious substance of the faith, must be disentangled and openly acknowledged to be what they are. If this is done, the Churches can still hope to regain their moral authority in the world. The common people above all things want truth, not ‘the truth’ according to this or that brand of religious doctrine, but truth

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<sup>415</sup> Neil Macvicar, ‘The Churches of Today Looked At’, *SAO*, December 1944, 163.

<sup>416</sup> *Ibid.*

<sup>417</sup> *Ibid.*

<sup>418</sup> *Ibid.*

itself, truth absolute. When complete candour has taken the place of circumlocutory obscurantism, the Churches will find themselves listened to as never before...<sup>419</sup>

By April of 1945, just a few months after ‘The Churches of Today Looked At’ appeared in print, Macvicar wrote to *The South African Outlook* editor and fulfilled the promise he had given Shepherd near the beginning of the publication process – to reveal his authorship of the letter if the letter was the cause of any outrage.<sup>420</sup> In his note of self disclosure Macvicar neither defended nor augmented his earlier arguments. He did, however, state a bit of his experience with theological writings, which he found largely “lacking in candour”, and his hope that the small treatise might spur the churches to, “rethink their whole position and restate it in a manner intelligible to ordinary thinking people”.<sup>421</sup> Macvicar’s comment regarding the lack of candour is especially noteworthy because it further explains both his reticence toward following along with something while not truly believing it, as well as his feeling that many elements in religious thinking (European or African) failed to seek truth, no matter the cost. In his mind, this was disloyal to the notions of intellectual honesty and sound curiosity which he thought he employed. In a short note of response to Shepherd after the matter had been put to rest in the *Outlook*, Macvicar confided that he believed most theological writers were more concerned with trying to prove something rather than working toward truth.<sup>422</sup> The impact of

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<sup>419</sup> Ibid.

<sup>420</sup> For his early promise of authorial revelation, “if any unpleasantness arises”, see Neil Macvicar, Johannesburg, to Robert Shepherd, Lovedale, 19 November 1944, MS 14,713(h), CL, LC.

<sup>421</sup> Neil Macvicar, in ‘Our Readers’ Views’, *SAO*, April 1945, 64.

<sup>422</sup> Neil Macvicar, Johannesburg, to Robert Shepherd, Lovedale, 27 April 1945, written at the bottom of the letter he had received from Shepherd just a few days earlier, Robert Shepherd, to Macvicar, 24 April 1945, MS 14,713(h), CL, LC.

the ‘common man’ article may not have been far reaching for others, but one important result was a more open explanation of what Macvicar himself did believe.

### *Believing in God*

In the early spring of 1945 Macvicar wrote to his friend that he had begun to record some aspects of the Christian belief he had held for the last fifty years. Whilst knowing that some of his views were not common to many Christians of his day (the recipient of his letter included), and not wanting to unduly offend, he nevertheless felt obliged to share his thoughts. At one point, after noting that he did not believe the virgin birth to be impossible, just a pagan import, he wryly remarked, “I know how far off the rails I am.”<sup>423</sup> But in a more open tone he later expanded on the thought process behind this work (eventually to be known as *Believing in God*), especially the scientific background which so heavily shaped his point of view on theological matters.

I know my point of view is out of joint with most people’s attitudes and opinions, but I would value your comments. I have opened my mind and I think my heart too. They seem inseparable, though I try to maintain a judicial attitude. Scientists I know, on this part, have not gone, and would hardly care to go as far as I have done. It seems to me natural and proper that faith should continue<sup>424</sup> the line of proved fact, not at a tangent but straight on, following the line of greatest probabilities rather than plunging into vacancy.<sup>425</sup>

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<sup>423</sup> Neil Macvicar, Johannesburg, to Robert Shepherd, Lovedale, 27 April 1945, MS 14,713(h), CL, Lovedale Collection, 1-2. He further believed that Shepherd would probably find his credo both “queer and inadequate”. Notice that this letter is distinct from the afore mentioned note.

<sup>424</sup> In the letter itself he first wrote, “...that faith should *depart from*...”, but then crossed that out and replaced it with, “...that faith should *grow*...”, before crossing that too out and coming to his final word choice, “continue” (emphases mine). While seemingly insignificant, they actually demonstrate an important aspect, not simply of his precision, but of very nature of the relationship between faith and reason.

<sup>425</sup> Neil Macvicar, Johannesburg, to Robert Shepherd, Lovedale, 7 May 1945, MS 14,713(i), CL, LC.

In light of Macvicar's earlier comments in, 'The Churches of Today Looked At,' in which he essentially accused many in the church of holding on to outdated ideas and his earlier letters to Shepherd in which he stated that he thought too many were pre-occupied with proving their suppositions rather than seeking truth, his comment here on the differences between the heart and the head are especially poignant. In his mind, many within the religious community had been too passionately tied to beliefs that were either off the mark or outrightly false and altogether ignoring the advances in modern knowledge. On the other hand, too many within the scientific community did not pursue or allow for the deeper truths of the Christian message – moral teaching, for example – tied as they were to purely scientific knowledge, and lacking any allowance for the supernatural. With both 'head' and 'heart', Macvicar was convinced that the ultimate truth(s) was sought for and found in a scientifically-acknowledged Christian point of view. Further, his last comments, regarding the theological lines that are followed from proved fact, again demonstrate his sincere desire not to overstate matters of theological truth. Just as he would not give assent to certain creedal beliefs in his early years for the Church of Scotland because he felt they were not reasonably true, here too he looks, with a scientific viewpoint, not at what may be possible, but at what seems so close to probable as to be reasonably certain. But in the end, Macvicar hoped *Believing in God* would benefit non-theologians like himself and it was with such people in mind that he wrote.<sup>426</sup>

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<sup>426</sup> Neil Macvicar, Johannesburg, to Robert Shepherd, Lovedale, 7 November 1945, 23 December 1945, MS 14,713(i), CL, LC.

As a personal statement of Christian belief, Macvicar's piece was certainly succinct. At a mere eight pages in length, it largely consisted of five very brief sections in the main body – 'God', 'An Approach Through Science', 'Christ', 'Uniformities Governing Human Experience', and 'The Bravest Act in History' – with another two tacked on as an afterthought<sup>427</sup> – 'Prayer' and 'Suffering is Indivisible'. While certainly open to critique for its failure to connect some of the thoughts or provide background material for the assertions,<sup>428</sup> it is also quite expressive in some of the plainly worded contentions it presents.<sup>429</sup>

Near the beginning of the paper Macvicar introduces what had long been perhaps *the* central question for much of his adult life, "Can we discover any correlation between our Christian faith and our present-day knowledge?"<sup>430</sup> While not a quandary for him alone, nor restricted to scientists, he sought to explain to lay people his scientifically informed theological suppositions and conclusions. Unlike some within the various fields of science, Macvicar was quite convinced that an atheistic removal of God, though impossible to prove one way or the other, naturally led to a loss of the proper moral order within mankind. In light of the still fresh events of World War II and his emphasis upon the moral tone as the centre of

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<sup>427</sup> Neil Macvicar, Johannesburg, to Robert Shepherd, Lovedale, 23 December 1945, MS 14,713(i), CL, LC.

<sup>428</sup> See the one page copy of the typed document with the comments of a Methodist Archbishop within South Africa, presumably connected with the Grahamstown District regarding "Belief in God" (note the slight variation in the title): No Name, MS 14,713(i), CL, Lovedale Collection. This document is connected with, Edward W. Grant, Healdtown, to R.H.W. Shepherd, Lovedale, 27 October 1945, MS 14,713(i), CL, LC, with Shepherd's handwritten dissenting comments at the bottom of the note.

<sup>429</sup> In contrast to the critique in the note above, see Shepherd's dissenting view and other opinions, Robert Shepherd, to Edward Grant, 30 October 1945, MS 14,713(i), CL, Lovedale Collection; Robert Shepherd, Lovedale, to Neil Macvicar, Johannesburg, 23 June 1945, MS 14,713(i), CL, LC, 1-4.

<sup>430</sup> Neil Macvicar, *Believing in God* (Lovedale: The Lovedale Press, 1946), 2.

Christian faith,<sup>431</sup> it is little wonder that this contention is dealt with near the beginning of his paper.

Macvicar's first postulate was that "the Universe is One".<sup>432</sup> With examples from chemistry, physics, and astronomy,<sup>433</sup> he lays out his case that with both content as well as behaviour, all of the universe is intimately connected and operates under the same rules. His second proposal maintained that earth, and life on earth more specifically, is, "a fair sample of the Universe as a Whole... a true Witness of the Whole".<sup>434</sup> The evidence of all physical life and a sense of wonder he gained from it led him to the conclusion that there was, most certainly, a Creator.

Our experience on this planet justifies a firm confidence that in the universe as whole there is, there must be, thought, purpose, affection, personality. Now Personality multiplied by Infinity – multiplied, that is, not merely in terms of space or time, but in terms of essence and significance – *Personality multiplied by Infinity equals God*.<sup>435</sup>

For Macvicar, this 'Infinite Mind' or 'all pervasive Being' coupled with his marvel at human life and high regard for moral features found their culmination in Christ, and was probably influenced by such thinkers as John Caird, the Scottish Theologian

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<sup>431</sup> See, for instance, his small devotional on Luke 18.1, Neil Macvicar, 'Sursum Corda', *SAO*, 2 January 1928, 12-13.

<sup>432</sup> Macvicar, *Believing in God*, 2-3.

<sup>433</sup> Macvicar cited two Christian thinkers, one who had been very influential to him in his younger days, Robert Flint, and another who was suggested by Shepherd, D.S. Cairns. In preparing *Believing in God*, he wrote to Shepherd, "You have not got Flint's Theism have you? I have long wanted to read it. As a youth I read his Anti-Theistic Theories. That was a book I got help from. Flint was a straightforward thinker – if my recollections are right." [Macvicar's emphasis] See Neil Macvicar, Johannesburg, to Robert Shepherd, Lovedale, 8 June 1945, MS 14,713(i), CL, Lovedale Collection. Regarding the inclusion of Cairns, one of his writings was suggested to Macvicar by Shepherd because he felt that much of Macvicar's thought was in keeping with the Principal of Christ's College, Aberdeen. See Shepherd, Lovedale, to Macvicar, Johannesburg, 18 May 1945, MS 14,713(i), CL, LC. See also: Robert Flint, *Theism*, 8<sup>th</sup> edition (Edinburgh: William Blackwood and Sons, 1891); Robert Flint, *Anti-Theistic Theories*, 5<sup>th</sup> edition (Edinburgh: William Blackwood and Sons, 1894); D.S. Cairns, *The Riddle of the World* (London: Student Christian Movement Press, 1937).

<sup>434</sup> Macvicar, *Believing in God*, 3.

<sup>435</sup> *Ibid.*, 4 (Macvicar's emphasis).

(and brother of the Oxford Philosopher, Edward Caird), who presented the Gifford Lectures at the University of Glasgow in 1892-93 and 1895-96.<sup>436</sup>

*Christ*, in respect of his being, not merely the greatest, but *the* supreme commanding Personality of the human race, is for us *the ultimate Witness*, the true *Word of God*, affording mankind a knowledge of the nature and purposes of that Infinite Personality; Who inheres in all things and works through all things; Who evolves life; Who both moves and rewards the enquiring mind of the scientist, the devotion of the worker for humanity, the loving heart of the mother; and, without Whom, not one sparrow shall fall on the ground.<sup>437</sup>

Significantly, Macvicar, in this whole section entitled, 'Christ', never once mentions the name Jesus. Without trying to extract too much from such a small portion of this brief piece, it does seem to demonstrate part of his theological opinion on the person and divine nature of Christ.<sup>438</sup> On the other hand, it may have simply been a conscious attempt to write in a specific manner as a departure from the typical use of banal language and associated definitions found in many theological writings.<sup>439</sup>

Whatever the case may be regarding his specific use of the term Christ, Macvicar here demonstrates his belief in the continuing work of God within the created order. God was unable to be confined not simply to the workings of the church, but to Christians as well. Echoing some of his other writing on this subject, he continued to demonstrate his earlier belief that the spirit of God was found

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<sup>436</sup> See the varied comments (some by Edward Caird, in the preface) in John Caird, *The Fundamental Ideas of Christianity*, Vol. I (Glasgow: James Maclehose and Sons, 1899), xvii-xx, 139-145.

<sup>437</sup> Macvicar, *Believing in God*, 3. (Macvicar's emphasis).

<sup>438</sup> It would be foolish to make too much of this, but based upon his earlier claims in 'The Churches of Today Looked At' as well as the contemporary work being done within the field of Early Christian history and Patristics during his day, it does not seem at all unreasonable to wonder if Macvicar could have believed in a more 'heretical' view of Christ and/or Jesus - some sense of a division between the divine Christ and the human Jesus.

<sup>439</sup> Macvicar spoke to this issue specifically in preparing this work: "P.S. As for the 'language' used in my paper, which to the Archbishop sounds Unitarian, I was deliberately avoiding as much as possible the use of current religious words. To an extent we, and perhaps especially some preachers, do not realise, many of these words have become so conventional and hackneyed as to have lost their meaning." Macvicar, Johannesburg, to Shepherd, Lovedale, 7 November 1945, MS 14,713(i), CL, LC, 2.



labouring in such things as the Boy Scouts, the *Children's Newspaper*, the Red Cross and Junior Red Cross, work in child welfare, international scientific co-operation – which he believed were vital portions of the progress of society and civilization, a broader interpretation than some earlier evangelical sentiments.<sup>440</sup> “Faith however is to-day taking new forms and finding new expressions. It has overflowed the Churches. The essentially Christian ideals of service and fellowship, forms of activity of its basic principle love, are now visible in many organizations and spheres...”<sup>441</sup> This providential involvement – whether in an act of creation or a continuing support of the creative process – was not for individuals, but for the whole.<sup>442</sup> His belief in the fullness of God’s activity within the world was, in some ways, quite organic in that there was not a deep divide between the work of the natural and supernatural. In a quotation that is absolutely central to any attempt to understand his thinking, not simply about theology, but about how he understood African worldviews, approached his medical work and other missionary activity:

My belief is that God reveals Himself, not by interruptions of the majestic order of His universe, but in and through that order, not through the abnormal but through the normal; that, though to our limited minds occurrences may not always be explicable, inherently there is nothing truly *super*-natural; that revelation and discovery are but opposite sides of the same process; that prayer is the conscious contact of the finite with the Infinite, of the creature with the Creator; and that all lofty inspiration in thought and in art, all honourable instincts, all holy desires, all love of truth, all ‘compassion for the multitude,’ come from God.<sup>443</sup>

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<sup>440</sup> Brian Stanley, ‘Christianity and Civilization in English Evangelical Mission Thought, 1792-1857’, in *Christian Missions and the Enlightenment*, ed. by Brian Stanley (Grand Rapids: William B. Eerdmans, 2001), 173.

<sup>441</sup> Macvicar, ‘Sursum Corda’, *SAO*, 2 January 1928.

<sup>442</sup> Macvicar, *Believing in God*, 5.

<sup>443</sup> *Ibid.*, 4 (Macvicar’s emphasis).

In a very real sense, Macvicar's missionary career was almost over before it ever began. He barely passed through the Church of Scotland's missionary candidacy programme in his first effort to go out on the African mission field in 1896. This partial impasse was due to some of his theological beliefs (or perhaps, *dis*beliefs). While he eventually made it to Blantyre, British Central Africa (present-day Malawi), as the medical officer of the mission,<sup>444</sup> he most likely would have failed in this endeavour had it not been for the backing of an influential Edinburgh minister.<sup>445</sup> Some members of the Foreign Mission Committee had challenged his orthodoxy on such central facets of traditional Christian belief in the veracity of the Trinity, miracles, the Resurrection, and the Incarnation.<sup>446</sup> It seems that throughout much of this long-standing 'discussion' (for it finally led to his dismissal from Blantyre), Macvicar did not actively deny that these dogmas could be/might be/were true; rather, he was not convinced that they were true (or perhaps could not be proved to be true), and therefore he would not – indeed, he felt that in good conscience, he *could* not – give his assent to such belief as the central tenet of what it meant to be

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<sup>444</sup> Macvicar was expressly sent out as the 'medical officer' of the mission and not a 'medical missionary'. For more on this discussion, see National Library of Scotland (hereafter NLS), Church of Scotland Foreign Mission Committee Letter Book (hereafter CSFMC LB), MS 7535, John McMurtrie, Edinburgh, to Alexander Hetherwick, Blantyre, 30 September 1895, 24 October 1895, 405–6, 470.

<sup>445</sup> The minister on the Foreign Mission Committee was the Rev. Dr A. Scott, minister of St George's Church, and shortly thereafter the Moderator of the Church of Scotland. Even Macvicar's own father, Rev. P. Macvicar, a Church of Scotland parish minister, did not recommend his son for missionary service, due to his theological beliefs: see NLS, CSFMC LB, MS 7535, John McMurtrie, Edinburgh, to Peter Macvicar, Manor/Peebles, 18 October 1895, 453–4. On Macvicar's side were also McMurtrie, the convener of the Foreign Mission Committee, as well as two experienced missionaries from Blantyre, D.C. Scott and A. Hetherwick. Note that it was eventually Hetherwick who turned on Macvicar, leading to his ouster, after D.C. Scott had left the mission and Hetherwick became the senior figure. For more details, see Shepherd, *A South African Medical Pioneer*, 20–3.

<sup>446</sup> For instance, NLS, CSFMC LB, MS 7535, A. Scott, Edinburgh, to A. Hetherwick, Blantyre, 15 July 1895, 353; NLS, CSFMC LB, MS 7535, J. McMurtrie, Edinburgh, to A. Hetherwick, Blantyre, 16 August 1895, 386.

(a) Christian.<sup>447</sup> The point gleaned in all of this is that from an early age and the advent of his work in Africa, Macvicar's personal belief was greatly shaped by post-Enlightenment scientific studies, a rationalistic mindset, and a critical attitude toward many traditional core Christian beliefs.<sup>448</sup> With this in mind, it is quite understandable that he did not hesitate to disband elements of the African worldview, especially as they related to medical and health issues, any more than certain European Christian dogmas. This point of view was made clearer in a few writings near the end of his life.

Discussion and debate over issues of Christian belief rose anew after Macvicar published an anonymous article in *The South African Outlook*, 'The Churches of Today Looked At'.<sup>449</sup> His conclusion was that the Christian churches needed to come together, recognise the deeper truths revealed in Christianity, and work toward the restoration of their proper place as the respected moral voice in the world. In reaching this conclusion, however, Macvicar trod upon the veracity of some of the biblical stories and accused some church leaders who believed in them as being obscurantist. In essence, Macvicar was calling them 'superstitious': believing in things that were held over from earlier times, but that he believed ought to have been relegated to history in light of modern advances in knowledge and thought, such as the higher criticism of the Bible. Perhaps needless to say, this

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<sup>447</sup> Shepherd, *A South African Medical Pioneer*, 61–75.

<sup>448</sup> His Unitarian and modern theology was by no means unique within the broader Scottish church during this time. It was, however, much more uncommon among most who were heavily involved in the Scottish missionary endeavour.

<sup>449</sup> 'By a Common Man' [N. Macvicar], 'The Churches of Today Looked At', *SAO*, December 1944, 163.

proved upsetting to some readers.<sup>450</sup> His point within the brief article, though, sheds light not only on his reading of the Christian scriptures but also on what themes he thought were critically important to Christian life and thought, such as brotherly love and work against racial injustice.

The final contribution on this matter comes from the treatise, published just a few years before his death, *Believing in God*. This little essay essentially dealt with the issue of reconciling his devoted belief in God with the modern achievements in knowledge, especially of a scientific nature. The continuation of his earlier-stated belief, that ‘All truth is God’s’,<sup>451</sup> led him to consider religious and cosmological points of view through the lens of scientific knowledge/truth. Consequently, there was a lack of discrepancy in his mind between the two positions – that is, religious belief and scientific truth were inseparable.<sup>452</sup> His most revealing statement, for this discussion, came in a section entitled ‘Christ’. After a paragraph of what could reasonably be called his personal creed on Christ, he wrote:

My belief is that God reveals Himself, not by interruptions of the majestic order of His universe, but in and through that order, not through the abnormal but through the normal; that, though to our limited minds occurrences may not always be explicable, inherently there is nothing truly *super-natural* ...<sup>453</sup>

While trying not to take this statement out of its proper context, it is entirely reasonable to apply this concept to help explain Macvicar’s reactions to African belief and worldview structures. As he did not allow for a Christianity laced with miraculous elements and, presumably, various spiritual beings, neither did he allow

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<sup>450</sup> See the series of letters to the editor of the *South African Outlook: SAO*, January 1945, 15–16; *SAO*, February 1945, 31–2; *SAO*, March 1945, 43–6. For Macvicar’s self revelation as author of the article and brief comments on the reaction, see his letter to the editor, *SAO*, April 1945, 64.

<sup>451</sup> Macvicar, ‘Some Ideals in the Native College Movement’, *CE*, December 1906, 236.

<sup>452</sup> Macvicar, *Believing in God* (Lovedale: The Lovedale Press, 1946), 2.

for similar aspects in the traditional African belief systems – especially as they related to the causes of illness, disease, and death or other aspects of healing. And since so much of the supernatural element of African traditional belief could not be tested under his methods, he found them non-existent and therefore untrue. In the end, Macvicar combined what he believed were the finest elements of his Western background, enlightened scientific knowledge and Christian charity, in his work against what he believed were the two greatest ills of African society, superstitious thought and fearful cruelty.

### **Concluding Remarks**

In their work on the impact of the London Missionary Society amongst the Tswana in southern Africa, the Comaroffs remarked that, “The ‘complete revolution’ was meant to be at once conceptual and concrete: a matter of culture and agriculture, of moral and material economics.”<sup>454</sup> While they were speaking about matters of agricultural concern, the point is echoed with Macvicar’s approach to African traditional methods of healing and understandings of ill health causation. He sought to fundamentally alter not simply the manner of curing, but to re-order the conceptual framework of how disease and ill health was caused. And just as some Scottish missionary workers, in the 1830s, were concerned with matters of ‘superstition’ and witchcraft among the Xhosa,<sup>455</sup> so was Macvicar, nearly one

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<sup>453</sup> Ibid., 4 (emphasis his).

<sup>454</sup> John L. Comaroff and Jean Comaroff, ‘Cultivation, Christianity, and Colonialism: Towards a new African Genesis’, in John de Gruchy, ed., *The London Missionary Society in Southern Africa, 1799-1999*, 56.

<sup>455</sup> Copy of Letter, D. Macfarlane, Renfrew, Scotland, to ‘Chief Satara of the Imidengi Tribe of Kaffers’, Caffraria, 20 September 1839, AMKWT, Lovedale Box, W827, 1-2.

hundred years later. Convinced that these beliefs were left over from pre-enlightened times, Macvicar found fault with wider African social ideologies.

If Macvicar was harsh in some of his assessments of African traditional methods of healing and conceptions of disease causation, he was no less mild in his assessments of some traditional tenets of Christian theology. His agreement with the then emerging higher criticism of the Bible, for example, demonstrates the great value he placed in the 'new knowledge' and ways of understanding and thinking about Christianity. As such, he viewed some traditional Christian beliefs as suspect, especially related to the divinity of Christ or other supernatural elements.

Alternatively, he embraced what has been termed 'social Christianity', which emphasised the need to confront elements of social inequality and poverty<sup>456</sup> - and in Macvicar's case, this social 'evil' was African 'ignorance'. Fundamental to understanding Macvicar's approach to his work is to understand him as a quintessential modern medical man who, while certainly exhibiting belief in God, did not believe in any supernatural involvement in the world. For him, the supernatural work of God was the working of the natural world. Following the Scottish theologian from the University of Edinburgh, Robert Flint, the progressive evolution of human history was leading to greater advances in truth, justice, and wellness.<sup>457</sup>

With this background in mind, and eager to be active in advancing the evolution of African progress, his reaction to worldviews which blamed witchcraft or

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<sup>456</sup> Stewart J. Brown, *Providence and Empire* (Harlow, England: Pearson Publishing Co., 2008), 354-355.

<sup>457</sup> Brian Stanley, 'Church, State, and the Hierarchy of 'Civilization': The Making of the 'Missions and Governments' Report at the World Missionary Conference, Edinburgh, 1910', in Porter, ed., *The Imperial Horizons of British Protestant Missions*, 60.

other supernatural elements for matters of disease causation, Macvicar sought to extend the reach of the mission's advanced health care education (scientifically based) and moral (Christian) teachings, primarily through an educated elite. These nurses, teachers, medical assistants, members of the South African Health Society, and other well educated young Africans were to be the *avant-garde* of a new South Africa – a generation of scientifically-informed and well respected Christian leaders. In addition, he laboured to reach the more common people and provide them with Western-based scientific understandings of the root causes for ill health, through the publication of a wide array of material on preventive health, nutrition, public health, disease contraction and treatment, and other areas of health care.

## Chapter 4: 'The Victoria Hospital and Dr Neil Macvicar'

### Introduction

#### *The Hospital*

Until the latter portion of the 19<sup>th</sup> century, the wealthier segments of British society did not travel to hospitals for medical treatment, as physicians came to them; hospitals were for abodes for 'the deserving poor'.<sup>458</sup> As the century progressed and medical treatment became more highly sophisticated, the hospital came to be seen as a special centre for restoring health. Accordingly, hospitals played an increasingly important and central role within missionary locations in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries,<sup>459</sup> just as they had within the general society back in Britain or the United States.<sup>460</sup> Mission hospitals were initiated, in this way, as a kind of shadowed reality of modernity; their importance replicated in their geographically transferred existence, very often to the margins of the 'civilized' world. They were made to reflect high Western standards of medical treatment, transplanted to locations that were otherwise largely, if not utterly, non-Western settings. South Africa, of course, varied in this last respect. Some missionary hospital-based efforts were very close to the white urban populations, while working amongst non-white/non-Christian

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<sup>458</sup> Lindsay Granshaw, 'Fame and fortune by means of bricks and mortar': the medical profession and specialist hospitals in Britain, 1800-1948', in *The Hospital in History*, ed. by Granshaw and Porter, (London: Routledge, 1989), 201.

<sup>459</sup> Christopher H. Grundmann, *Sent to Heal!*, 175-178; David Hardiman, 'Introduction', in *Healing Bodies, Saving Souls*, 17-20; Agnes Rennick, *Church and Medicine*, 220-268.

<sup>460</sup> Joan Lane, *A Social History of Medicine*, 83-95.



populations.<sup>461</sup> Others were specifically set in rural areas far removed from the more opaque Western influence, such as the Church of Scotland Nessie Knight Hospital at Sulenkama in the Eastern Cape, superintended by Dr R.L. Paterson, or the hospital overseen by Dr George Gale at Tugela Ferry, in KwaZulu-Natal.<sup>462</sup>

*Growth of Mission Hospitals in South Africa*

In the last years of the 19<sup>th</sup> century, there were but a handful of Protestant mission dispensaries operating within South Africa. Missions at Blythswood (established by the Free Church of Scotland), Cape Town (The Church of England's St. Philip's Dispensary), Durban (operated by St. Aidan's Medical Mission for Hindus), and Miller and Tutura (both begun by the United Presbyterian Church Mission) all operated dispensaries. In addition to these dispensaries, there were a total of three mission hospitals: the American Board of Commissioners for Foreign Mission's hospital at Amanzimtote (Adams) in Natal, the Rhenish Missionary Society's hospital in Stellenbosch, and the Victoria Hospital at Lovedale.<sup>463</sup> By the establishment of the Republic of South Africa, in 1910, this number had grown to five mission-run hospitals in South Africa.<sup>464</sup> This compared with 18 mission hospitals within South-Central Africa, 14 in South-West Africa, 12 in East Africa, 9

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<sup>461</sup> See, for instance, Gaitskell's discussion on urban endeavours, Bridgman Hospital in Johannesburg and St Monica's Home in Cape Town in, 'Women, Health and the Development of Medical Missions: Some South African Reflections', 68-71.

<sup>462</sup> In the late 1920s, the United Free Church (which merged with the Church of Scotland in 1929) established these two small hospitals, though it should be noted that Gale moved to the Tugela Ferry site from the Gordon Memorial Mission. Gale changed the physical location because there was not a sufficient water supply at the previous setting.

<sup>463</sup> James S. Dennis, *Centennial Survey of Foreign Missions*, 193-195.

<sup>464</sup> This included Lesotho (Basutoland) and Swaziland as well. *Statistical Atlas of Christian Missions* (Edinburgh: Student Volunteer Movement for Foreign Missions, 1910): 64, 89-90.

in North-East Africa, 6 in Western Africa, 5 on Madagascar and Mauritius, and 1 in North-West Africa.<sup>465</sup>

Though the number of hospitals and dispensaries on the continent, and within South Africa more particularly, grew at a tremendous rate during the first decades of the 20<sup>th</sup> century,<sup>466</sup> their presence did not always dictate greater access to them by the African masses. To further complicate matters, there was an increasing divide between access to doctors in the rural setting and in the larger cities. By the late 1930's, twenty percent of the South African population lived in the Union's nine largest urban centres, sharing fifty percent of the nation's doctors. In an even more marked contrast, Cape Town had one doctor per 400 people, while the ratio in the racially segregated black African area of the Eastern Cape, then termed 'Transkei', was a staggering one to 30,000.<sup>467</sup>

While this portion of the thesis does not concern itself with the overarching medical hospital history of South Africa, this period mirrors the span of time Dr Neil Macvicar worked as a medical missionary at Lovedale's Victoria Hospital. This chapter provides an examination of both the hospital and the varying aspects of the work carried out there, touching on a number of themes: religiously, financially, pedagogically, missiologically, etc. It thus offers a unique view of missionary hospital work carried out during an important era of mission and South African history. Before evaluating and analysing some of these elements of medical mission

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<sup>465</sup> Ibid. The total number of dispensaries in the whole of the continent was 144.

<sup>466</sup> Mackenzie and Truswell, *Mission Hospitals in South Africa*, passim. This succinct book provides but a brief history on the hospitals/missions recorded; however, it omitted information on the Victoria Hospital, Lovedale (and possibly others).

<sup>467</sup> 'The South African Doctor', *The Lancet* 234, Issue 6055 (16 September 1939): 659.

work at the Victoria Hospital, I believe it is necessary to present an overarching narrative on the hospital's history during this period over the next several pages. In so doing, I hope to provide for the reader a summary of the hospital's growth and key features during the period of Macvicar's tenure as Superintendent, often revealing the methods and emphases in his approach to medical missionary work.

## The Victoria Hospital under Dr. Neil Macvicar, 1902-1937

### *The Early Years*

Upon Macvicar's arrival near the end of October 1902, he treated a few hundred patients – 110 "Natives", 15 "Europeans", and 135 Lovedale boarders before the end of the year. Many of these people, in his opinion, were quite sick and he acknowledged that some requested in-patient care, a plea he would have consented to under normal circumstances.<sup>468</sup> But owing to Rev James Stewart's desire for a slow start-up, lest unforeseen problems, such as financial difficulties, force the closure of the hospital again, the fourteen beds were not employed for in-patients.<sup>469</sup> However, soon thereafter, the beds were once again being used<sup>470</sup> and 1903 witnessed 167 in-patients treated, in addition to just fewer than 2700 out-

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<sup>468</sup> Neil Macvicar, 'Victoria Hospital', *CE* 1 January 1903, 7. He also reported that he had signed seven death certificates in the short span of time he had been there (approx 7 weeks).

<sup>469</sup> James Stewart, Edinburgh, to D.A. Hunter, Lovedale, 22 August 1902, MS 16,457 LC CL.

"I have mentioned to him [Neil Macvicar] what is proposed about the Hospital, though his first care ought to be the institution, patients, and the general health there. We must put this matter right now, and not have a repetition of the inverted method followed by McCash." James Stewart, Edinburgh, to D.A. Hunter, 19 September 1902, MS 16,457 LC CL.

<sup>470</sup> Macvicar remarked that several times during the month of August every bed was taken. *CE* September 1903, 132.

patients.<sup>471</sup> By February of 1904, the building had not been brought to full capacity, owing in part to Macvicar and his family residing in one portion of the building and the Matron, Miss Mary Balmer, and a few student nurses using rooms occupying another area. By this time there were 18 beds available for use, but a campaign was underway to double the capacity with a building expansion of two additional wings.<sup>472</sup>



Postcard picture from early 20<sup>th</sup> century of Victoria Hospital with new west wing in foreground and Sandili's Kop behind. This is one of the earliest photographs of the hospital.<sup>473</sup>

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<sup>471</sup> Neil Macvicar, 'Victoria Hospital, Lovedale, Report for the Year 1903', *CE*, February 1904, 21. Note that Macvicar's figures in the preliminary report in the January *CE*, page 7, were almost certainly lower because he finished that statement before the end of the year, in time for publication – 2300 against 2690; 160 versus 167.

<sup>472</sup> Neil Macvicar, 'Victoria Hospital, Lovedale, Report for the Year 1903', *CE*, February 1904, 23.

<sup>473</sup> Photograph no. 1000 [no authorship, no date], 'Victoria Hospital, Lovedale', Lovedale Photographs, CL LC.

While waiting until adequate funds were received before beginning the construction of the east wing of the hospital, by August of that year, the west wing was roofed.<sup>474</sup>



Rear photo of Victoria Hospital with West Wing completed.<sup>475</sup>

By the latter portion of 1904 the new wing was being utilised and the extra room allowed for a 30% increase in the number of in-patients intakes, 217; without counting Lovedale students, the number of out-patients was over 3,000, also an increase of more than 30%.<sup>476</sup> Oddly enough, 1905 witnessed a bifurcation in these

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<sup>474</sup> 'Lovedale News', *CE*, September 1904, 132.

<sup>475</sup> Photograph no. 1151 [no authorship, no date], 'Front of Victoria Hospital, Lovedale, South Africa', Lovedale Photos, CL LC.

<sup>476</sup> Neil Macvicar, 'Victoria Hospital', *CE*, January 1905, 3. In terms of data analysis, there is a fundamental difference between some of the statistics used in these reports, especially regarding out-patients. One figure that is often used refers to the number of visits paid to the hospital/dispensary – a particular person might come a few times for treatment regarding the same illness or problem; this is different from the number of cases (or individuals) treated, though an individual may very well have



trends, with the number of in-patients continuing to rise (260), while the out-patient total fell to 2,760.<sup>477</sup> While the veranda and balcony of the west wing were being completed in June 1906, still more funding was needed before beginning construction of the east wing.<sup>478</sup>



Photograph taken during the construction of the East Wing of the Victoria Hospital. Note the three African nurses, in uniform, standing in the centre of the picture.<sup>479</sup>

During the early teens of the century, with both wings of the hospital completed, the number of in-patients continued a steady ascent: 1911 saw 323 admissions, with a

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come to the hospital at various times during the year for separate health needs. Note that Macvicar also tried to make a point of clarification on Lovedale boarders, whether or not he counted them in varying lists, though not always.

<sup>477</sup> Neil Macvicar, 'The Victoria Hospital', *CE* January 1906, 5.

<sup>478</sup> *CE* June 1906, 147.

daily average of 18.4; 1912: 356 and 20, respectively; and 1913 (with a marked rise in the number of enteric fever cases) had 418 in-patients, a daily average of 24.2.<sup>480</sup>

*Continued Expansion during 1910s and 1920s*

By the start of World War I, the Victoria Hospital was again nearing full in-patient capacity, with an average of just over thirty-two in-patients per day in 1914 and slightly less the following year.<sup>481</sup>



Front view of Victoria Hospital with both West and East wings completed.<sup>482</sup>

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<sup>479</sup> 'Erection of Victoria Hospital' [no authorship, no date], 1845/SH 034/H/B, AMKWT Photo Collection. On the back of the photo are the handwritten remarks, "c. 1910. The Second Wing in the Process of being built; about 1910; built by Roskelly Bros. and Dunstan".

<sup>480</sup> 'The Victoria Hospital, Lovedale. Report for 1913', *CE* March 1914.

<sup>481</sup> 'Victoria Hospital, Lovedale: Report of the Medical Superintendent for the Year 1914', *CE* February 1915, 32; 'Victoria Hospital, Lovedale – Report for 1915', *CE* February 1916, 30.

However, by 1917, in-patient intake lessened considerably,<sup>483</sup> something Macvicar attributed to a couple of different reasons. On the downside, there had been a typhus outbreak and, for medical reasons (lack of adequate staff and the space to sequester typhus patients), they felt they had to refuse treatment to typhus or probable typhus cases. In addition, the government imposed restrictions on travel within that area of the province, due to the typhus epidemic, and a number of potential in-patients were not able to go to hospital. In a more positive manner, Macvicar believed that, notwithstanding the typhus outbreak, health was generally better within the district. He was certain this was due to particular economic and environmental factors – higher wages, a good year for crops, and high prices for agricultural products – all of which, he believed indirectly contributed to better health.<sup>484</sup> Such comments reflect his belief that wider social circumstances had important effects on the health of Africans and not simply elements of African belief systems.

After the Influenza Pandemic and the cessation of the First World War, the 45-bed Victoria Hospital witnessed a marked rise in the average number of in-patients (41.7) in 1919.<sup>485</sup> Such increased numbers demanded the purchase of extra beds, though even with these additional beds there was not enough capacity and some individuals had to be turned away. With such conditions expected to continue, Macvicar sought a long-term solution through another expansion. In building a separate house for the Medical Officer (Macvicar and his family), the west wing of

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<sup>482</sup> No. 1151 [no authorship, no date], Lovedale Pictures, CL LC.

<sup>483</sup> 1917 saw a total of 468 in-patients under treatment during the year, while 1915 had witnessed 552 (a difference of 84); see, *CE* February 1916, 30, *CE* February 1918, 25.

<sup>484</sup> 'The Victoria Hospital, Lovedale', *CE* February 1918, 25.

<sup>485</sup> 'The Victoria Hospital, Lovedale. Report for 1919', *CE* February 1920, 28. 1919 also witnessed the largest number of out-patients: 3,738 (with a total of 11,136 out-patient attendances for the year).



the hospital was then to be remodelled; the refurbished quarters were to house the nurses and free up space for a total of twenty five additional beds.<sup>486</sup> The expansion was also sought, specifically, to address tubercular patients.<sup>487</sup>

The 1920s witnessed continued expansion for the hospital, both in patient load as well as bed space. While there were great difficulties with financial measures, due in part to governmental policy changes enacted in 1913,<sup>488</sup> there were also bright spots and optimistic shades of what Macvicar believed were a sign of better conditions to come. In a 1922 report for the hospital, he recounted a rather unusual aspect of the previous year:

The year just ended was in one respect remarkable. It might almost be called the year of no epidemics.... On the whole, however, the district seems to have been remarkably clear of fevers. Whether this is due to great cleanliness and greater care to avoid infection it is difficult to say, but.... Perhaps the [preventative and public health] teaching and the law<sup>489</sup> together are having their desired effect.<sup>490</sup>

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<sup>486</sup> Ibid., 28-29.

<sup>487</sup> 'The Victoria Hospital, Lovedale, 1921', *SAO* February 1922, 31.

<sup>488</sup> See section below, in 'Victoria Hospital and Finances' for greater detail on this issue.

<sup>489</sup> In addition to his emphasis upon matters of health education (discussed further in chapter 6), Macvicar believed both the implementation and fulfilment of governmental laws and policies, such as the cessation of movement during an outbreak of typhus, were more than warranted in matters of public health. As a promoter of Western health care practices and understandings, he undoubtedly endorsed the implicit encroachment of Western standards, such as patented medicines, as well as the enforcement of laws such as the Witchcraft Act of 1895, which forbade the killing of witches, thereby limiting (at least in theory) the authority of diviners and some other methods of African traditional healing. Elizabeth van Heyningen, 'Medical Practice in the Eastern Cape', in *The Cape Doctor*, 172-173.

See also the interesting account of fellow Scottish missionary, Donald Fraser, in Malawi, and his promulgation of the observance of civil law along with the agency of the mission. His account was born amidst conditions following the Influenza Pandemic which witnessed the rise of a number of "witch doctors" and "chiefs of the underworld". Fraser responded with a strong sermon in which he "expounded the Levitical law, not diminishing the terror of the death penalty. Then I took the gazetted law of the Protectorate, and translated it clause by clause, emphasizing the severity of the punishments to which witch doctors are liable, and especially a clause which threatens chiefs and headmen who wittingly allow certain practices within their districts. Before I had finished there was no doubt that I had the law of Moses and of the Protectorate at the back of me, when I denounced the sorcerers who were abroad." This double-pronged attack – the role of the church as well as civil law and government authorities – was not simply welcomed by many missionaries, but seen as absolutely necessary. Donald Fraser, 'Exit the Witch Doctors', *The Record of the Home & Foreign Missions of the United Free Church of Scotland*, 1920, 180-181. For additional comment on this episode, see Hokkanen, *Quests for Health in Colonial Society*, 301-303; Markku Hokkanen, 'Scottish Missionaries

Such optimism was short lived and probably overconfident in the effects of the mission's impact upon health in the region. Just two years later, he began a hospital report, "The year has been one of profound depression due to drought."<sup>491</sup> Accordingly, the people were quite ill, especially with conditions related to malnutrition.<sup>492</sup>

In 1926 the hospital underwent minor refurbishments (which had been held off for budgetary reasons).<sup>493</sup> By the end of 1927 the hospital was enlarged to 75 beds, and Miss Shena Macvicar (Neil and Jessie's daughter) was added to the staff as surgeon. Shena Macvicar had studied at her father's alma mater, the University of Edinburgh, and, in addition, went on to become a Fellow of the Royal College of Surgeons, Edinburgh.<sup>494</sup> With the addition of a surgeon, the number of patients being treated as compared to the years immediately preceding increased; a near doubling up in the daily average number of in-patients, and a 160% increase in the number of surgeries performed.<sup>495</sup> By the end of the decade Shena's husband, Dr Richard Ross, was added to staff as the Assistant Medical Officer and the building

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and African Healers: Perceptions and Relations in the Livingstonia Mission, 1875-1930', *Journal of Religion in Africa* 34, no. 3 (2004): 333-335.

<sup>490</sup> 'Report of the Victoria Hospital, Lovedale, 1922', *SAO* February 1923, 39.

<sup>491</sup> 'Report of the Victoria Hospital, Lovedale, 1924', *SAO* February 1925, 45.

<sup>492</sup> *Ibid.*, 45-46.

<sup>493</sup> 'Report of the Victoria Hospital, Lovedale, 1926', *SAO* February 1927, 32.

<sup>494</sup> S. Macvicar received her M.B. Ch.B. from Edinburgh University in 1924 and F.R.C.S.E. in 1927. By 1929 she had received her M.D. from the University of Edinburgh with her thesis, *Notes on 208 Cases of Scurvy Treated in the Victoria Hospital, Lovedale, South Africa, - During the 12 Months November 1927 – November 1928*.

<sup>495</sup> 'Report of the Victoria Hospital, Lovedale, 1928', *SAO* February 1929, 28-29. In a rather staggering increase, the daily average number of in-patients in 1928 was 81.3 – well over the 75 beds technically available.

was once again operating beyond its maximum bed capacity.<sup>496</sup> Even with 75 beds and a dozen extra cots, the hospital had a daily average of over 91 in-patients for 1929<sup>497</sup> and as many as 108 at one point.<sup>498</sup> They therefore sought to enlarge the building again by raising the roof of the middle section of the building and adding a second floor at an estimated cost of £2,500. By this point in time, Macvicar and Hunter estimated that there had been approximately 12,000 in-patients treated at the hospital since its inception in 1898, and roughly 100,000 out-patient attendances.<sup>499</sup> In 1930 a separate building was constructed to house the white nurses – rather telling of the segregationist policies, even at a ‘liberal’ mission institution – which opened additional space within the hospital building, bringing the number of beds to 125.<sup>500</sup>

The building expansion first proposed back in the late 1920s was finally completed in 1934, with a formal opening ceremony on the 5<sup>th</sup> of May that year. The new remodel allowed for 175 beds, with the new first floor especially set up for the treatment of children with tuberculosis. Indeed, that year witnessed over 70 such in-

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<sup>496</sup> Both Dr and Mrs Ross remained on the staff, a situation abnormal in some mission society policies (see chapter 3 for more on Neil and Jessie Macvicar’s problem in this regard at the Blantyre Mission). Not uncommonly, wives of male missionaries served unofficially, without pay or recognition. And as related to me in personal conversation with former medical missionaries, Dr Robin and Storm Burnett, up through the 1960s, the Church of Scotland Foreign Mission strongly encouraged wives (as in the case of a nurse married to a doctor) not to work. It was maintained that such conditions led to greater domestic/family stress.

<sup>497</sup> *Report of the Victoria Hospital, Lovedale, 1929*, (Lovedale: Lovedale Institution Press, [1930]), 3-5.

<sup>498</sup> Neil Macvicar and D.A. Hunter, [“Letter Seeking Monetary Support”], single page, typed copy document, [1929], MS 16,457 LC CL.

<sup>499</sup> Ibid.

<sup>500</sup> *Report of the Victoria Hospital, 1930*, (n.p. [Lovedale: The Lovedale Institution Press], n.d. [1931]), 1, 4. It seems Nurse Violet Dongo was the first black staff nurse, having coming on in January of 1925 (she had completed her training at the Victoria Hospital in 1919). By 1928 she was a Sister, in charge of three wards and the maternity work. However, it seems she was the exception, as the rest of the higher nursing positions were still relegated to whites.

patients.<sup>501</sup> In addition, a new Maternity Section was established, provided in part through a bequest by Donald Fraser, the well known Scottish missionary.<sup>502</sup> These last few years under Macvicar's Superintendency did not witness further expansion of the hospital, though just prior to his retirement, the South African Public Health Department contacted the Board regarding its desire to open up a new 90-bed Pulmonary Tuberculosis Hospital on the current hospital grounds.<sup>503</sup> The close of 1937 witnessed the end of Dr Neil Macvicar's 35 year medical career at the hospital as well as other major staff changes. Dr Richard Ross resigned his seven year long Assistant Medical Officer position in May of that year, and Dr Shena Ross resigned from her 10 year long post as the hospital Surgeon at the end of the year.

1938 witnessed a new Superintendent, Dr A.F. Grattan Guinness, Physician, Dr Dorothy Ryan, and Surgeon, Dr W.C.J. Cooper. It was under these doctors' guidance, along with Matrons and other key members of staff, that the next era of the hospital-based medical work of the mission was undertaken, and the changes were rather far reaching. While a few of the Sisters, such as Misses M. Wilson and E.A. Lord, had been supervising early childhood clinics in the surrounding areas, by 1939 Dr Ryan had also started visiting two villages per week in a bid to further primary medical contact as well as matters of public and preventative health education.<sup>504</sup>

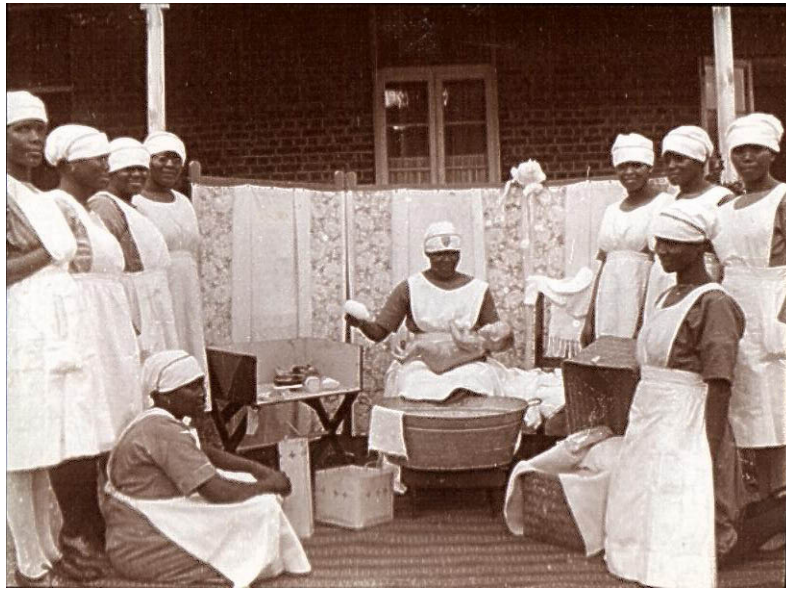
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<sup>501</sup> *The Victoria Hospital, Lovedale. Report for the Year 1934*, (n.p. [Lovedale: The Lovedale Press], n.d. [1935]), 3.

<sup>502</sup> *Ibid.*, 4.

<sup>503</sup> 'Report of the Victoria Hospital, 1936', *SAO* February 1937, 36.

<sup>504</sup> 'The Lovedale Hospital Report for the Year 1939', *SAO* March 1940, 55. These district services were stopped, however, in 1942 due to staff shortages caused by WWII. *Lovedale Hospital Board. Report for the Year 1942*, (n.p. [Lovedale]: The Lovedale Press, n.d. [1943]), 1. For more on Ryan's thoughts on her work, especially as related to childhood and female medical issues, see, 'Child Welfare Work', in the booklet *Native Health: Three Addresses to the Ciskei Mission Council*, (n.p. [Lovedale]: The Lovedale Press, 1940): 13-20.



Lovedale nurses demonstrating paediatric care – ‘How to wash a baby’ – presumably with community childhood clinics or midwifery training. Medical personnel from the Victoria Hospital conducted such work in the 1930s and began maternity and midwifery training in 1940. ‘Hygiene’ and ‘Cleanliness’ were important subjects in mission Hospital-based public health education, while a great deal of female run missionary medicine focussed upon health subjects for women and children.<sup>505</sup>

1939 also witnessed the completion of the David Hunter Training School building (for nurses and medical aids) and the commencement of a Maternity Training School for midwives.<sup>506</sup> By 1940 the Victoria Hospital campus could boast the presence of

<sup>505</sup> No. 01690/SH032, Victoria Hospital/Lovedale Photographs, AMKWT.

An excellent example of Scottish female missionary medical emphasis in Africa during this period is seen in the example of Agnes Fraser, wife of the well known Donald Fraser, who served in Malawi (then Nyasaland) and later at the Copper Belt Mission. Though not officially a ‘medical missionary’ (as the wife of a full-time missionary), Dr Fraser’s work often emphasised health care work among women in her approach to medical mission. See, [Agnes] Mrs. Donald Fraser, ‘The Doctor As Friend’, in *Friends of Africa*, Jean K. Mackenzie and others (Cambridge, MA: The Central Committee of the United Study of Foreign Missions, n.d. [1928]), 84-119; *The Teaching of Healthcraft to African Women* (London: Longmans, Green and Co., 1932); ‘Bags’, *Other Lands* July 1939, 159.

<sup>506</sup> ‘The Lovedale Hospital Report for the Year 1939’, *SAO* March 1940, 55.

the new government financed-Lovedale run Macvicar Tuberculosis Hospital,<sup>507</sup> a building which, by the mid-1940s, saw the average number of in-patients (for the whole hospital campus) reach just over 250.<sup>508</sup>

### ***The Victoria Hospital through Varying Lenses and Capacities***

Dr Neil Macvicar saw the mission hospital as the greatest means of medical missionary work. In his view the Victoria Hospital encapsulated the finest and highest aims which Western trained medical missionaries sought to bring to the people. The building itself was to be kept and operated in such a way that it physically demonstrated many Scottish ideals, such as cleanliness, economy, efficiency, and a quiet atmosphere. As a medical centre, the Victoria Hospital aimed not simply to cure, heal, and relieve pain, but to actively demonstrate Western biomedical understandings of the causes of sickness and disease, and consequently, how to then prevent such illness. The surgery performed under its roof was believed by the missionaries (and others) to proclaim the progress of Western advances in medicine over and against African traditional methods of healing.<sup>509</sup> In training African nurses and hospital assistants the Hospital sought to fulfil a function which Macvicar believed was even greater than the training of teachers, and indeed whose influence he hoped would become just as widespread. Religiously, the hospital was to provide love and enlightenment to the ‘heathen’ as well as encouragement to the

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<sup>507</sup> S. Boyce, *The Victoria Hospital, Lovedale, South Africa*, (n.p. [Lovedale]: The Lovedale Press, n.d. [c. 1941]), 2.

<sup>508</sup> *Lovedale Hospital Board Report for the Year 1945* (n.p. [Lovedale]: The Lovedale Press, n.d. [1946]), 4.

Christian patient. As a purveyor of such 'Christian civilisation', Macvicar was convinced the Victoria Hospital stood at the very centre of mission work in South Africa:

...I think it may be said that a Hospital is a powerful Missionary Agency and that its influence tells in directions that are required in South Africa, relieving suffering, undermining superstition, and developing among the natives a high type of Christian character.<sup>510</sup>

At its very core, the Victoria Hospital tried to operate as an agent of change – religiously, medically, culturally, etc. And it is in this way that it can be viewed as a striking example within the wider missiological, as well as medical and colonial, endeavour.

As a solitary location which was sometimes quite far from patients' homes<sup>511</sup> the Hospital threatened to change the very nature of care for people in the rural setting – from localised to centralised. No longer were the sick or injured to be treated within their own community or local area. Rather, the plan centred on having them travel away to the 'location of healing'. In this way, the hospital became a kind of pilgrimage destination with the sick journeying from afar for what would have been promoted as a site of near miraculous healing, something which was not

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<sup>509</sup> Van Heyningen, 'Medical Practice in the Eastern Cape', in *The Cape Doctor*, 182.

<sup>510</sup> Macvicar, 'The Place and Aim of Medical Missions in South Africa', *CE* August 1904, 117-118.

<sup>511</sup> In a study of 100 consecutive patients, conducted by the Victoria Hospital, the *average* distance travelled by out-patients was 13 miles one way – 26 miles roundtrip! 'Report of the Victoria Hospital, Lovedale. 1925', *SAO* February 1925, 40. In a clear demonstration of devoted African interest, Welcome Zondi has brought out the example given by Africans travelling far distances for medical help and advice from non-medically trained missionaries. See the example relayed by the USP.G missionaries, Mr and Mrs Robinson, in Kwazulu-Natal, of one person being carried 30 miles for treatment, and another 100 miles for medical advice in the middle of the 19<sup>th</sup> century – see, Zondi, *Medical missions and African demand in Kwazulu-Natal*, 71. See also, Hodgkin, *The Way of the Good Physician*, 38-40. The demonstration of the miles travelled for medical work was often used as a facet of missionaries' self-propagation, especially in information conveyed to the mission-supporting public back home – their publication of such facts demonstrating high rates of demand for their work, and hence their importance within their field.

particular to Christian hospitals during this period, but evidenced in other cultures’ ‘healing destinations’.<sup>512</sup> This was seen especially in times of overt or far reaching crisis, as in the Influenza Pandemic of 1918-19<sup>513</sup> or during local droughts (while people could still travel, of course); it almost mirrors the flight to missions and towns or other ‘European’ locations after the ramifications of the Xhosa Cattle-Killing.<sup>514</sup> Perhaps the Hospital in some ways mirrored the urban centre in South Africa; having been evangelised as a place of Western opportunity, promise, and progress, and delivering on some of those accounts, it was also a social disruptor, breaker of dreams, and sometimes the location of death. In the following sections, I present not simply a history of the Victoria Hospital and Dr Macvicar’s work through this agency, but particularly important ways in which the hospital might be more fully examined and understood in mission history.

### The Victoria Hospital and the Treatment of Ill People

Throughout the missionary discourse of the 19<sup>th</sup> and 20<sup>th</sup> centuries, there is a common perception by the missionaries of what they believed were striking differences between African and Western standards in the actual *settings* of health care provision (let alone the standards of healing). Agnes Rennick has commented on some elements within this opposing binary – common themes or word usage, especially in an antagonistic sense – which were used to distinguish between the ‘superior’ medical missionaries and the ‘inferior’ elements of the African norms:

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<sup>512</sup> Andrew T. Crislip, *From Monastery to Hospital* (Ann Arbor: The University of Michigan Press: 2005), 120-123.

<sup>513</sup> At Lovedale, the Victoria Hospital was also ‘brought to the people’, so to speak, *CE* December 1918, 185-186. See also the section below on this period in ‘Treatment of Disease’.

<sup>514</sup> Laidler and Gelfand, *South Africa*, 296-297.



Viewing the doctor's work as an extension of that of Christ the Healer, the use of analogies between 'darkness' and 'heathenism' and 'light' and 'Christianity' would remain dominant themes within this medical discourse. Imperialistic theories of the superiority of Christianity and western medicine over indigenous religion and therapies also underpinned this discourse, which provided additional confirmation to British supporters of mission of medicine's essential evangelising role.<sup>515</sup>

The hospital, in the missionary mindset, deepened the bifurcation between these competing systems. British standards for a hospital setting became all the more formed around the post-Lister ideals of sterility and cleanliness. Upon Macvicar's arrival at Blantyre, Malawi, in 1896, there was both shock and disappointment expressed at the state of the conditions in which he was to conduct his medical practice: they were on a par with typical African standards! After relating the environment for treating both out-patients and in-patients, Macvicar commented:

There is no nurse to attend to the making and giving of the food. Were it not for the help temporarily obtained from other departments of the Mission, it would be out of our power to give the severe cases anything like the attention their condition demands. Moreover it is exceedingly difficult to watch intelligently patients' progress when they lie huddled together on the floor of a smoky hut. It may be said that the raw natives prefer this kind of life, and that to give them an airier building and unaccustomed delicacies would be mistaken kindness. On the contrary we hold that comfortable surroundings, cleanliness, careful nursing and proper diet are so essential to the treatment of persons seriously ill whatever be their race, that in the absence of these conditions the medicines is a mere apology for treatment. If we cannot improve upon the native methods of treatment we have no reason for our existence as a Medical Mission.<sup>516</sup>

In addition, the atmosphere – quiet and orderly, most particularly – was believed to enhance the patients' recovery: 'How else could they get the proper rest needed?' This was often remarked upon in direct juxtaposition to what were seen as lesser African standards surrounding typical living and treatment conditions. In his

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<sup>515</sup> Agnes Rennick, *Church and Medicine*, 84.

<sup>516</sup> 'Medical Notes', *LWBCA* 98 April 1896, 5. While this magazine entry was not explicitly ascribed to Macvicar, everything points to his authorship or, at the very least, his assent to the points that are presented. Note that he had arrived at Blantyre the month prior and there had not been any 'Medical Notes' sections in the journal prior to this April issue.

first full annual report on the work of the hospital for 1903, Macvicar wrote about this stark difference, as well as what he hoped would be the wider educative role:

Only those who have seen the dirt and the discomfort around which sick natives, even well-to-do natives, lie in their own homes, can realize how much of a comfort and relief is afforded by a well-appointed hospital... The patients' friends, many of whom come to visit them in the afternoons, must carry away with them from the Hospital some idea of how to make sick people comfortable. In this respect, as well as in respect of order and cleanliness, a hospital is an educative influence here just as it is at home.<sup>517</sup>

This last sentence is all the more striking because it reveals the connection which was drawn between the 'primitive' or 'raw' Africans and the urban poor in Scotland or England. Such comparisons, while not always explicitly made, represent a kind of shadowed circumstance in Africa, to the vast public health measures undertaken in places like Edinburgh in the 19<sup>th</sup> century. On a more specific note, take Sir Robert Philip's words regarding the presence and value of his 'Open-Air' in-patient treatment for pulmonary tuberculosis patients (predominantly lower working class) at the Victoria Hospital for Consumption in Edinburgh, which he was in charge of for several decades during the late 19<sup>th</sup> and early 20<sup>th</sup> centuries, and which Macvicar used as a model for some of his treatment methods:

The educative value of such residence cannot be overestimated. The patients learn unconsciously how to treat themselves. They realize how practically true it is that open air, day and night, and sunlight are their best friends, and that attention to hygienic measures can be their salvation. They thus become on their discharge from the hospital apostles of the new faith, and one frequently hears of the results of their teaching in their own homes.<sup>518</sup>

The hospital, both in the mission setting, as well as in Scotland, was most certainly seen as a place of vital importance for treating both the illness as well as the person.

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<sup>517</sup> 'Victoria Hospital, Lovedale', *CE* February 1904, 22.

<sup>518</sup> Robert W. Philip, 'On the Universal Applicability of the Open-Air Treatment of Pulmonary Tuberculosis', in *Collected Papers on Tuberculosis* (Oxford: Oxford University Press, 1937), 12. This article was first published in the *British Medical Journal*, 23 July 1898.

Even the manners in which patients were treated, both by African traditional healers as well as their family, were marked not simply as deeply divergent from Western practices by the missionaries, but also less curative. It is rather striking, I believe, to note the analogy between the hospital and church, in this respect. The Scottish model of an orderly, quiet, pristine, and separate atmosphere and surroundings (of hospital and church) are a marked contrast to a more socially vibrant and integrated atmosphere as seen in the typical South African model (traditional home/hut). For the Scottish doctor of the early 20<sup>th</sup> century, like Macvicar, a quiet presence was believed to be of great importance to the relief of suffering and healing process;<sup>519</sup> whereas for some African patients, the presence of family or friends in the midst of treatment (all while far away from home) would have likely been seen as reassuring and of great comfort.<sup>520</sup>

The subject of the treatment of people at the Victoria Hospital also provides an opening for brief discussion on the subject of the doctor/patient relationship and associated issues of power and authority. In his article, 'Power and Powerlessness in Medical Mission', Dr Gerrit Ter Haar has brought forward an important aspect of this work in South Africa, claiming, "For many years – especially during the period when hospitals were managed by the church and not by the state – the medical missionary in this country functioned from a power base, controlling people,

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<sup>519</sup> 'The Victoria Hospital, Lovedale', *CE* February 1920, 28.

<sup>520</sup> At the Victoria Hospital, friends and relatives were only allowed during certain hours, according to the hospital rules, unless they had been explicitly given permission by the M.O. or Matron.

In visiting Japanese hospitals in the late 19<sup>th</sup> c., a Western missionary noted the striking difference between Eastern and Western styles in this regard: "As a rule the inmates are not in long wards, as at home, but from one to four or five in one room, and they can either be nursed by a hospital nurse or by their own friends, who can sleep and live in the same room." 'Japanese Hospitals and Christian Work', *CE* April 1898, 54.

patients, the patients' families, visitors and members of staff."<sup>521</sup> While any institution or organisation must have rules and systems to abide by, the power base creating and controlling patients' rights within the Victoria was managed by the Superintendent and the Matron. One of the earliest pieces of literature on the 'Rules and Regulations' of the hospital outlined some of the elements which were to be observed by the patients, including such basics as no smoking within the building, or rules against men entering the women's wards and vice versa. Beyond these more elementary regulations, the Victoria Hospital functioned in a way which sought to bring the patients into a Western based frame of reference regarding how they ought to conduct, or construct, daily life. Once physically well enough to help, patients were expected to work within and on the Hospital grounds during their stay. Unless they had express permission from the Matron, they were not allowed 'outside' food or drink.<sup>522</sup> During the summer they were to be up at 6 am (6.30 am during winter), and to bed at 9 pm. One last provision worth mentioning noted, "Patients shall assist as far as possible in maintaining order and cleanliness in the Hospital and grounds. They shall not interfere with any of the Hospital assistants or servants in the discharge of their duties."<sup>523</sup> All such rules were to be observed with the understanding that the patient would be expelled if he/she did not follow them, at the Superintendent's discretion.<sup>524</sup> In this atmosphere, the Victoria Hospital's work was

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<sup>521</sup> Gerrit Ter Haar, 'Power and Powerlessness in Medical Mission', *Missionalia* 18.1 (April 1990): 51. Ter Haar was a Dutch medical missionary who began working in South Africa in 1956 at the Dutch Reformed Rietvlei Mission Hospital.

<sup>522</sup> Rules on such issues as bringing food into the hospital varied, even within the same place over time; see Hokkanen, *Quests for Health in Colonial Society*, 346.

<sup>523</sup> *Victoria Hospital, Lovedale, South Africa*, (n.p., n.d. [c. 1902]) Lovedale Box, AMKWT, 10-11.

<sup>524</sup> *Ibid.*, 9, 11. In fairness, it is worth mentioning that both the Superintendent and the Matron were also governed under explicit regulations regarding their duties and responsibilities, see *Ibid.*, 5-8. However, this must be viewed in the primary context of employment within a homogenous medical

not limited to the elements of biomedicine, but sought to ‘civilise’ (Westernise) the patients under its roof – drawing a wide bifurcation between the African patients’ norms and what the missionaries believed were superior Western techniques and standards of healthcare provision and methods of attaining wellness.<sup>525</sup>

As well as the doctor-patient relationships and issues of authority regarding treatment of the sick, it is appropriate to examine how Macvicar typed or defined ‘success’ in this work of healing. While others have helped to analyze missionary language and its place in the over-arching realm of imperializing,<sup>526</sup> I restrict this portion to the more exclusive aspect of medical work and treatment.

During the decades of work at the Victoria Hospital, Macvicar and the other medical practitioners saw a wide array of medical cases. Of these ‘cases’, the people themselves came from a wide variety of ethnic and religious backgrounds. In the earliest years, Macvicar recorded the racial backgrounds of his patients, probably in an attempt to demonstrate the wide and impactful influence the Hospital was having to the readers (and therefore sponsors, or potential sponsors) of his annual reports in *The Christian Express*. 1903, the first full year of operation under his superintendency, saw “Fingo”, “Kaffir”, “Dutch”, “Hottentot”, “Bechuana”, “English”, “Basuto”, “Zulu”, “German”, “Italian”, and “Greek” patients, which he

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community, which is quite different than the cross-cultural interactions at play between the British medical personnel and the African patients. (Though ‘Europeans’ were treated at the Hospital for the first year and a half after re-opening, their numbers and the short period of treatment makes it largely insignificant.).

<sup>525</sup> See Hokkanen, *Quests for Health in Colonial Society*, 342-346. Note especially Hokkanen’s insight on the role and place of the African ‘therapy managers’ in Malawi – the individual’s family and friends involved in (and often later excluded from) the treatment and care.

<sup>526</sup> See, Hokkanen, *Quests for Health in Colonial Society*, 34-41.

further divided into the groupings of: “White”, “Hottentot”, and “Bantu”.<sup>527</sup> In addition, he recorded the religious affiliation of those receiving in-patient treatment at the Hospital, which demonstrates not simply an open policy of treatment, but also provides a glance at the religious norms in the area around Lovedale – both in the town of Alice, and beyond. These included Presbyterian, Wesleyan, Anglican, Congregational, Heathen, French Protestant, Roman Catholic, Greek Church, Baptist, Moravian, and Lutheran.<sup>528</sup>

Of greater interest than this, is the categorization he employed in the discharge record of in-patients because this so closely relates to the very mission of the hospital: making patients ‘well’. In yearly reports Macvicar often recorded the number of in-patients, out-patients, number of second-visits, etc. He also included, under the in-patient category, the condition in which those patients left the hospital. These were broken down into four sections: ‘recovered’, ‘cured’, or ‘well’; ‘improved’ or ‘relieved’; ‘not any better’, ‘not relieved’, or ‘not improved’; and ‘died’.<sup>529</sup> What is perhaps most striking about these numbers is not simply the upward or downward trends they display, but how they relate the reality of a sizable number of deaths or those ‘not relieved’. In an atmosphere in which Western biomedicine and its practitioners viewed themselves as the heralds of the progress of civilization and scientific thinking, the reality is that the hospital was continually

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<sup>527</sup> “Fingo” was the largest number: 88, with “Kaffir” second: 58, the rest had totals ranging from one to six.

<sup>528</sup> ‘Victoria Hospital, Lovedale. Report for the Year 1903’, *CE* February 1904, 21-22.

<sup>529</sup> See, for example the Victoria Hospital Reports in *CE* and *SAO* for the years, 1903, 1913-1919, 1925, 1929, and the 1930’s.

confronted with death or an inability to ‘cure’.<sup>530</sup> Perhaps unsurprisingly, Macvicar’s attitude toward this reality of death resided in his belief that at least some comfort could be given to the dying: “It is true that many of our patients come to the hospital at a stage when no cure is possible. They seem to value the relief from pain and the comfort obtainable at the hospital.”<sup>531</sup> What exactly the patients themselves may have been thinking, however, remains another issue.<sup>532</sup>

An oft-cited response amongst so much of the medical missionary discourse during this period was something along the lines of, ‘If only the sick or injured person had come to me sooner’.<sup>533</sup> For some cases this was probably true, especially as some advances in Western biomedicine had certainly occurred in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries, and surgery in particular seemed a remarkably superior method to some traditional forms of healing.<sup>534</sup> Though rarely, if ever, acknowledged in the missionary discourse, however, is the reality that the Victoria Hospital was unable to

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<sup>530</sup> Though dealing with a very specific aspect of medical care during this period – patients with advanced pulmonary tuberculosis – Sir Robert Philip advocated, from Edinburgh, the retention of these patients in hospital to their death, under both the aspect of providing palliative care as well as for public health reasons. The hospital then became a place ‘to die’, while the sanatoria became locations of healing. Philip, ‘Public Aspects of the Prevention of Consumption’, in *Collected Papers*, 49-51. This article was first presented as the inaugural address to the Sanitary Society of Edinburgh in November 1906.

In the limited provision of Western healthcare for Africans in rural South Africa during most of this period, it is no surprise that the Victoria Hospital was consequently a place where many ‘went to die’.

<sup>531</sup> Neil Macvicar, ‘The Hospital, its Work and its Opportunities’, *CE* July 1916, 106.

<sup>532</sup> The late eminent medical historian, Roy Porter, has brought up the importance of the patient’s view in the fuller understanding of the encounter, and how medical history has often neglected this. However, due to the constraints of space and the difficulty of procuring proper accounts, this thesis cannot address this very significant issue of the popular African response to Macvicar and the Lovedale mission medical work. See, Porter, ‘The Patient’s View: Doing Medical History from Below’, *Theory and Society* 14, no. 2 (March 1985): 175-198.

<sup>533</sup> Such sentiment was often combined with heavy resentment and condescension if the patient had first gone to a traditional African doctor. Though not a medical missionary, a striking example of this is related by Dr Fitzgerald, a government doctor at Grey Hospital in King William’s Town, ‘Witch Doctors of South Africa’, *The Lancet* 80 (11 October 1862): 396.

discharge a majority of their in-patients as ‘cured’ much of the time.<sup>535</sup> In this case, the hospital often sought to provide physical relief from pain and other complications, such as sleeplessness, through the administration of drugs, thus becoming a centre for palliative care.<sup>536</sup> For other conditions, such as leprosy (which was incurable at that time), the Victoria Hospital cared for patients, providing stabilization, then passed them along to leprosariums.<sup>537</sup> Of course, as a mission hospital, it is not surprising that issues such as dying were met with elements of prayer, religious services being held daily in the hospital itself.<sup>538</sup> While the Hospital acted as a Western biomedical and civilising influence, the religious element of its care and treatment was also important.

### The Victoria Hospital as Sacred Space

From the 18<sup>th</sup> century onwards in Britain and other Western nations, there had been an increasing bifurcation in notions of care for the body and the soul. Professional practitioners were available to help in each of these areas, with ministers or priests for the soul and medical practitioners for the body, while there were also corresponding centres for such matters, with churches and hospitals fulfilling those

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<sup>534</sup> Grundmann, *Sent to Heal!*, 175; Bryant pointed to an underlying element for proper surgery: the knowledge of human anatomy, *Zulu Medicine and Medicine-Men*, 15-18.

<sup>535</sup> See for example, Neil Macvicar, ‘The Victoria Hospital’, *CE* January 1906, 5. Of the 260 in-patients for the previous year, 105 left ‘cured’, about 40%.

<sup>536</sup> *Ibid.*

Note an opposing opinion offered by Ruth Young during this period, who advocated for limited missionary medical expense and emphasis be placed on preventative healthcare, not in the traditional realm of the relief of suffering or curing. Ruth Young, ‘Preventive Medicine and Medical Missions’, *IRM* 16 (1927): 563-564.

<sup>537</sup> D.A. Hunter, “B.B.” *Beds in the Victoria Hospital, Lovedale, South Africa*, Lovedale Box, AMKWT, 3.

<sup>538</sup> *CE* February 1918, 25.



roles.<sup>539</sup> Yet the realm of medical missionary work often sought to bring these distinct realms into closer spheres of interaction.<sup>540</sup>

Mission hospitals throughout Africa and the rest of the world functioned as religious institutions in addition to their capacity as medical facilities, a facet of the work that has been noted by some historically critical perspectives,<sup>541</sup> while typically lauded within the mission discourse of the time. Dr. Omar Kilborn, a Canadian Methodist medical missionary who worked in China in the late 19<sup>th</sup> and early 20<sup>th</sup> c. expressed the common sentiment thus: “The aim is to develop and conserve a thoroughly Christian and evangelical atmosphere in and about the institution, so that all who come in touch with the Mission hospital will feel and know a power there which is not of man.”<sup>542</sup> There is also an interesting example taken from Japan in which missionaries visited secular Japanese hospitals speaking with the patients, handing out tracts, holding religious services, etc., in a kind of foreign missionary chaplaincy role.<sup>543</sup> Charles Good has maintained that while the government-run hospitals which superseded the UMCA hospital-based work in Malawi (then Nyasaland) in the post-colonial period provided a greater number of beds and enhanced capacity for the number of people treated, the spiritual and emotional

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<sup>539</sup> Christoph Benn and Erlinda Senturias, ‘Health, Healing and Wholeness in the Ecumenical Discussion’, *IRM* 90, no. 356/357 (January/April): 8.

<sup>540</sup> “A Medical Missionary” [Anonymous], *The Medical Mission of the Church: A Vision and a Response*, 4.

<sup>541</sup> G.L. Chavunduka, ‘Traditional Medicine in Africa’ in *Transforming Health*, ed. by Eric Ram (Monrovia, California: MARC Publications, 1995), 290-291.

<sup>542</sup> Omar L. Kilborn, *Heal the Sick* (Toronto: The Missionary Society of the Methodist Church, 1910), 196.

<sup>543</sup> ‘Japanese Hospitals and Christian Work’, *CE* April 1898, 54. While not explicitly ‘medical missionaries’, this might be seen as ‘missionaries to a medical setting’.

support offered by the missions was unlikely to have been surpassed.<sup>544</sup> Yet very little attention has been paid to the hospital itself as a kind of sacred space. This section examines some of the varying capacities in which religious work figured in to the Victoria Hospital's functions and notes some of the varying dimensions of such spiritually-minded efforts.

As a building in which issues not simply of improving health, but life and death are often present, there is little wonder that a mission hospital might be regarded by patients and practitioners alike as a special place with deeply religious undertones.<sup>545</sup> While the medical treatment of patients, as well as teaching and training, occupied central positions in the central objectives of the hospital, as seen in its very charter: "to attend to the spiritual as well as the bodily welfare of the patients".<sup>546</sup>

Macvicar himself was a part of the religious activity within the hospital. In his early years at Victoria, daily prayers were held amongst the staff, a ritual which the Superintendent believed kept them focused on their purpose in being there, in addition to having what might be viewed as a kind of 'team unifier' effect amongst the personnel.<sup>547</sup> Daily prayers or services were also held within the hospital

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<sup>544</sup> Good, *The Steamer Parish*, 405-406.

<sup>545</sup> A central difference, however, may have existed in the thought of the missionaries and the African people. For, while many missionaries would have seen their own hospital and the efforts made there toward bettering health as intrinsically good and beneficial, the fact is that 'sacred spaces', and/or places of death, were not always welcoming spaces.

Though Macvicar provided the example of a non-Christian whose friends believed that the hospital may have provided a 'safe place' where the enchantments from a bewitching would not be able to penetrate, so to speak, in this case, in the form of a bewitched snake. This undoubtedly is tied to a notion of the hospital as a Western Christian space. See, Macvicar, *Side-Lights*, 8.

<sup>546</sup> See number 5 under 'Objects of the Hospital', *Victoria Hospital, Lovedale, South Africa*, (n.p. n.d. [c. 1902]), 1.

<sup>547</sup> 'The Victoria Hospital, Lovedale. Report for the Year 1903', *CE* January 1904, 23.

amongst the in-patients both in a more formal sense, led by a member of the Hospital or Lovedale staff (and presumably with translation when necessary), as well as amongst in-patients themselves.<sup>548</sup> On Sundays, services were held in English, with the Xhosa translation sometimes supplied by one of the nurses. Macvicar emphasised the message of God's love and Providence in his messages, writing, "...[the services] are a means of keeping ever before the patients the love of God in Christ Jesus our Lord, and also of pointing out that both sickness and health are sent us by our Heavenly Father in love and for our perfecting."<sup>549</sup> Though rather succinct, this statement is crucially important because it presents a view which was in direct opposition to traditional African ideas at the time. The belief that sickness was sent directly by a loving God contradicted, firstly, the notion that the illness (or injury, et cetera) was the result of lesser supernatural entities (i.e. ancestors) or the result of witchcraft. Secondly, it seems to imply a dimension of nearness between God and individuals – a conception rather foreign to some traditional southern African worldviews. And finally, it views disease or sickness as a result, not of social malice, anger, jealousy, et cetera, but of love and performed under the auspiciously good work of God.<sup>550</sup> It might also be held up as a striking example of theology contrary to that in many AICs, Pentecostal, or charismatic groups within southern Africa.

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<sup>548</sup> See *CE* January 1906, 5; *CE* March 1914; *CE* February 1915, 32; *CE* February 1916, 31; *CE* February 1918, 25.

<sup>549</sup> 'Victoria Hospital, Lovedale. Report for the Year 1903', *CE* February 1904, 23.

<sup>550</sup> In his later years, even though he was not addressing the specific aspects of affliction due to illness, Macvicar wrote on the subject of suffering, expressing an analogous idea which optimistically saw good coming from difficult, if not evil, conditions: "It seems as if, in some manner obscure as yet to our finite minds, some great purpose is being served [in suffering].... It may be that a decenter [sic] world is in the making, a world more free from pride and selfishness – some day to become truly Christian". Neil Macvicar, *Believing in God* (Lovedale: The Lovedale Press, 1946), 7.

Yet, while Macvicar was interested and involved in the spiritual aspects of the hospital, he rarely, if ever, wrote on the subject of its role in conversion – perhaps due to his more scientifically gauged mind or simply because of the unseen nature of such a subject. He sometimes commented on how difficult it was to measure the ‘religious influence’ of the Victoria Hospital. Such work, unlike the results of his medical labour which he typed in five categories (‘cure’, ‘improved’, ‘relieved’, ‘not cured’, and ‘died’), he did not think could be easily quantified.<sup>551</sup>

Part of this is probably due to the fact that the hospital largely catered to ‘Christian’ patients. The early reports attest to the fact that the vast majority of the people utilising the hospital, both in- and out-patients, identified themselves as Christians.<sup>552</sup> Even by 1915, Macvicar seemed to lament the fact that so few of the in-patients for the previous year were ‘Heathen’, an indication to him that the Hospital had not properly crossed over socio-religious lines in the outlying communities:

Although the hospital has now in a considerable degree won the confidence of the Christian people resident in the neighbourhood, this cannot be said of the heathen population. Only 39 out of the 496 patients admitted were heathen. The rest were Presbyterians 275 (U.F.C. 194, Mzimba’s 68, F.C. 13), Wesleyans 136, Anglicans 38, and members of various smaller bodies 8.<sup>553</sup>

Indeed, one cannot help but wryly point out that the following comments, the concluding remarks of Macvicar’s last ever report for the hospital, were made about 40 years after the hospital had first been established!: “Heathen people, who at first were afraid to enter hospital, are now coming in increasing numbers. The

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<sup>551</sup> ‘Victoria Hospital, Lovedale. Report for the Year 1903’, *CE* February 1904, 22-23; ‘The Victoria Hospital, Lovedale. Report for 1913’, *CE* March 1914; ‘Victoria Hospital, Lovedale, Report for the Year 1915’, *CE* February 1916, 31.

<sup>552</sup> *CE* February 1904, 21-22.

opportunities of spiritual service are greater than ever before and the new developments will increase these opportunities in the years to come.”<sup>554</sup>

As the Superintendent, Macvicar did not retreat from engaging with patients, even one-on-one, regarding religious or spiritual matters. Indeed, he believed prayer was an important component of his ‘Christian medical work’ at the hospital.<sup>555</sup> In the following citation, note the ‘remedying affects’, so to speak, Macvicar believed religious acts achieved. In his estimation, they both complemented and interacted with the hospital-based medical work:

As the years passed, daily contact with the people led the writer to a deepening sense of the mental and spiritual distresses that in very many cases complicated or underlay their physical ills.

Two convictions were formed. One was that it was the duty of the doctor, the medical missionary, to speak to these people and pray with them himself, whether or not he was able to obtain help from others. Limited as may be one’s insight, stupid and clumsy one’s touch, yet one feels that, having in the privacy of the consulting room learnt things, often of a confidential and intimate nature, special to each sufferer, a corresponding responsibility rests upon the medical missionary to help these people who have given him their confidence, by understanding and sympathetic prayer and by reading passages of scripture specially selected to meet their needs.

The other conviction was that at this stage of the spiritual experience of the Native people, when their hold upon truth is still in many cases weak and the stress and backward pull of their old faith are still strong, their supreme and paramount need is to gain a secure consciousness of God. It was with this specially in mind that passages were selected for services and for the daily ward prayers. The New Testament was of course mainly drawn upon, but one frequently turned also to the psalms. The psalms are so full of comfort in times of perplexity and distress. And in the Xhosa translation, the great psalms lose none of their power.<sup>556</sup>

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<sup>553</sup> ‘Victoria Hospital, Lovedale’, *CE* February 1915, 32.

<sup>554</sup> *The Victoria Hospital, Lovedale. Report for the Year 1937*, ([Lovedale]: The Lovedale Press, [1938]), 8.

<sup>555</sup> In a letter to his good friend, and historian of Lovedale, Robert Shepherd, Macvicar noted his use of Harry Emerson Fosdick’s works (including *The Meaning of Prayer*, first published in 1915) in religious interactions with both patients and nurses while back at the Victoria Hospital. Neil Macvicar, Johannesburg, to Robert H.W. Shepherd, Lovedale, 9 July 1945, MS 14,713(i) LC CL.

<sup>556</sup> Neil Macvicar, *Side-Lights upon Superstition* (Lovedale: The Lovedale Press, 1946), 56-57. At the end of this quotation, Macvicar included a footnote noting to the reader that one must be careful with one’s selections from the Psalms, omitting certain parts when necessary. It is too bad he didn’t expand upon the specifics of what he believed ought to be omitted.

Note the emphasis on the religious space and confident tone in Macvicar's perspective on the patient's view and importance of a Hospital:

The religious influence of a well conducted Mission Hospital is always great. The quietness gives opportunity for thought. The daily services provide material for thought. The whole atmosphere is religious, and it is hardly possible for a patient to be for two or three weeks in Hospital without receiving some very definite religious impressions. Many testify to this as they leave Hospital.<sup>557</sup>

A spiritual conversion, of course, would have been desired, but it was not the central driving force in Macvicar's approach to his mission work. In fact, he viewed the notion of conversion as a greater transformation to Western standards: religiously, cosmologically, scientifically, educationally, socially, etc.

#### *Approach of Maria Knox Bokwe*

There was a notable difference in the religious approach or expression in this regard, however, between Macvicar, on the one hand, and others, such as Mrs Maria Knox Bokwe, the 'Bible Woman', or Dr Grattan Guinness, who became Victoria Hospital's Medical Superintendent after Macvicar's retirement. It is not necessarily easy to classify the approaches particular missionaries took in their work, considering the limited resources one has to draw on, not to mention the even more limited view such sources give regarding the whole of such work. Nevertheless, it seems that if Macvicar's religious emphasis through the medical work at Victoria Hospital was approached as the demonstration of Christian love and care, Mrs Bokwe's work seems to have been of a more traditionally evangelical tone.<sup>558</sup>

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<sup>557</sup> Neil Macvicar, 'The Place and Aim of Medical Missions in South Africa', *CE* August 1904, 118.

<sup>558</sup> One must be mindful of the discourse such writing takes place in: a missionary magazine, heavily dependent upon donations from the readers – readers who are, in fact, often giving toward such medical work because of the evangelistic opportunities provided.

Maria Knox Bokwe was married to the well known Xhosa leader John Knox Bokwe.<sup>559</sup> He was one of the most important figures within South African Christianity in the late 19<sup>th</sup> and early 20<sup>th</sup> century, especially well known for his missionary work, authorship, church work, and contribution as an African composer of hymns and other musical pieces.<sup>560</sup> Mrs. Bokwe, in her own right, was highly regarded, especially within the larger Lovedale community as well as the Bantu Presbyterian Church. Typical of her day, she was said to have been a great ‘helper’ to her husband’s ministry as a Presbyterian minister at Ugie in Tembuland in the Eastern Cape. After his death in 1922 left her a widow, she continued to be active in Christian work, including activity in the Women’s Association of the Bantu Presbyterian Church, as well as later travel to Scotland to join in the centenary celebration of the Women’s Foreign Mission Committee in 1937-1938 and address meetings throughout the country.<sup>561</sup>

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<sup>559</sup> Maria was his second wife; his first wife, Lettie Ncheni had died.

<sup>560</sup> Grant Olwage, ‘John Knox Bokwe, Colonial Composer: Tales about Race and Music’, *Journal of the Royal Musical Association* 2006 131.1: 1-37; Veit Erlmann, ‘‘Africa Civilised, Africa Uncivilised’: Local Culture, World System and South African Music’, *Journal of Southern African Studies* 20.2 (June 1994): 165-179 (especially 171-175).

<sup>561</sup> ‘Fort Hare and Lovedale News – Mrs. J.K. Bokwe’, *SAO* November 1937, 268.



Photo of Maria Bokwe, centre, along with Misses Ponnarangam and Pen, taken while the three were in Scotland on a Church of Scotland Women's Foreign Missions tour.<sup>562</sup>

Most important to this study is Bokwe's work on the Victoria Hospital staff as 'Bible-woman',<sup>563</sup> and who laboured in this capacity for a number of years, in the

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<sup>562</sup> Photo courtesy of T. Jack Thompson.

<sup>563</sup> This title was probably used in the general sense of an evangelistic worker, though it is possible that Knox Bokwe worked in association with the South African Bible Society, founded in the Cape in 1820, whose female workers were known as 'Bible women'. See also the brief statistics and information: 'Bible-Women and Zenana Visitors', in Dennis, *Centennial Survey of Foreign Missions*, 240. See also, Deborah Gaitskell, 'Hot Meetings and Hard Kraals: African Biblewomen in Transvaal Methodism, 1924-60', *Journal of Religion in Africa* 30, no. 3 (August 2000): 277-309, particularly 277-282.

In an early report from the Glasgow Medical Missionary Society (a 'home' mission organization) the role of Bible-women was seen as important, and especially the enhanced position of Bible-women nurses: "Our Bible-woman, Mrs King, resigned at the commencement of the year. Two others – Mrs Wilson and Miss Stalker – were engaged, not merely as Bible-women, but as *Bible-women Nurses*. This scheme, as mentioned in last report, was adopted to carry out in a more effectual manner the twofold (medical as well as missionary) aspect of the Society. Your Directors were very desirous that the Bible-women who were engaged should possess a thorough knowledge of nursing, and be fully equipped for their important duties in visiting and nursing the sick." *The Fifth Annual Report of the Glasgow Medical Missionary Society*, 1872, 4.



1920s and 30s. Her reports often highlighted conversions or re-commitments, especially by “Red” Africans.<sup>564</sup>

The following story, which directly highlights not only the spiritual aspect of the Hospital, but Knox Bokwe’s approach to her work, was typical of such reports:

It is the keen and interested spirit of the Reds that touches one most deeply and that encourages when the most enlightened show indifference and impatience. Often an old Red woman has prayed very fervently, thanking God for this one opportunity they have to worship Him [at hospital]. One young Red woman sang the verses of a chosen hymn so well that I afterwards wanted to know where she had learnt them. In tears she told me that she had once been at school, and a Christian. Having married a heathen she lost sight of her past life and its achievements. Our service had touched her and she promised to interest herself in God’s work once again, and to try and influence her husband and his people for the right.<sup>565</sup>

Such work concentrated on the transmission of a Christian identity to patients, especially through the work of sermons, talks, prayer services, literature, and personal conversation.<sup>566</sup> In so doing, it also furthered the religious identity of the hospital in the minds of all involved.

#### *Approach of Dr A.F. Grattan Guinness*

Mrs Knox Bokwe was not the only one active in this regard. Upon Neil Macvicar’s retirement, Dr Alexander Fitzgerald Grattan Guinness took charge of the hospital and in so doing carried on the spiritual work which had been a central part of

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<sup>564</sup> “Red”, “Red Kaffir”, or “Red Blanket” were common descriptions used by many in the white South African community to describe Xhosa or Bantu-speaking people that dressed and lived in more traditional manners. There was a common bifurcation drawn in the missionary (and other colonial discourse) between what was seen as ‘Christian’ and ‘civilised’ on the one hand, and ‘Native’ or ‘Heathen’ and ‘primitive’ or ‘raw’; the terms first mentioned belong in this latter group. Missionary writings are filled with images of ‘before’ and ‘after’ photos and accompanying text in efforts to demonstrate the colonial civilising effects.

<sup>565</sup> ‘Report of the Victoria Hospital, Lovedale, 1928’, *SAO* February 1929, 30. See also, *Report of the Victoria Hospital, Lovedale, 1929* (Lovedale Institution Press), Lovedale Box, AMKWT, 7, in which Knox Bokwe reported, “Christians have been revived and the heathen stirred up”; ‘Victoria Hospital Report, Lovedale, 1932’, *SAO* February 1933, 37.

<sup>566</sup> *Victoria Hospital, Lovedale, Report for the Year 1933* (Lovedale Press), Lovedale Box, AMKWT, 7. In addition to Bibles, she distributed pamphlets, such as *Umsebenzi wo Moya Oyingcwele* (The Work of the Holy Spirit).

the Victoria Hospital, but with what might be seen as a more ‘Evangelical’ bent.<sup>567</sup>

In his first annual report for the Hospital as Medical Superintendent, Guinness wrote with a hopeful tone about the spiritual care of the patients, noting that trained ministers connected with Lovedale were active in this shared venture. The irony of this work is that in so doing, one might argue that Guinness was thereby actually further secularizing the ‘medical missionary’ role by assigning the ‘spiritual’ care of patients to ministers while the medical personnel were only to care for the biomedical concerns of the patient. According to Rennick, such action would characterize Guinness and his colleagues ‘mission doctors’ as opposed to ‘medical missionaries’ or ‘medical ministers’.<sup>568</sup>

Guinness also mentioned a special service held within the hospital during his time there, enhancing the notion of the hospital’s shared role as a sacred space: “A unique occasion this year was the special service, held in the Hospital, to receive into the Church one who had learned his first stories of Jesus within these walls, and who

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<sup>567</sup> One cannot help but see some sense of irony in the light of Macvicar’s conversation back in the early 1890’s with H. M. Stanley, and Macvicar’s comment about never being allowed to work at Grattan Guinness’s Mission in the Congo, as it was ‘terribly orthodox’, see Shepherd, *A South African Medical Pioneer*, 17.

Dr A.F. Grattan Guinness was a member of this very influential and important mission-orientated family, whose patriarch, Henry Grattan Guinness (grandfather of A.F.) worked with Dr Thomas Barnardo in London, in addition to starting the East London Missionary Training Institute (eventually becoming Cliff College), the Livingstone Inland Mission, the Congo-Balolo Mission, and Regions Beyond Missionary Union. See also, ‘Fort Hare and Lovedale Notes’, *SAO* October 1937, 240.

<sup>568</sup> While I agree with Rennick’s contention that the term ‘medical missionary’ is very far reaching in its description, I am very hesitant to further confine classifications further, such as ‘mission doctor’ vs. ‘medical minister’. While priorities may come out in the surviving written discourse (more or less involved with preaching, for example), it may be very difficult in certain circumstances to delineate personal emphases or even unknown personal encounters with patients and what occurred within these everyday (unrecorded) settings. With that said, however, the nuances of how they understood and approached their work should certainly be noticed and further understood. Agnes Rennick, *Church and Medicine*, 140-141.

had later come to accept the same Jesus as his personal Saviour and King.”<sup>569</sup> Such special religious services or rituals within a hospital were not uncommon, as evidenced by the UMCA doctors and nurses who performed special baptisms within hospitals in Malawi at the beginning of the 20<sup>th</sup> century.<sup>570</sup> Nevertheless, this report demonstrates a strongly evangelical aspect of Guinness’s approach in the hospital and how it was fused with the medical workings amidst a time which has been seen by some historians as an increasingly secularised period.<sup>571</sup>

### The Victoria Hospital as Training Centre and School

As a fully and well-equipped establishment (relatively speaking), Lovedale’s Victoria Hospital was seen by many as a leader in the South African field of medical missions. From its inception, one of the hospital’s main aims was to train nurses, and this endeavour, along with the training of medical assistants, grew tremendously over the years.<sup>572</sup> Yet the training of nurses and medical assistants was not the only

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<sup>569</sup> *The Victoria Hospital, Lovedale. Report for the Year 1938* (The Lovedale Press), Lovedale Box, AMKWT, 4.

<sup>570</sup> Rennick, *Church and Medicine*, 114.

<sup>571</sup> Vaughan cites the period after World War II as the turning point in this ‘secularization’ process of medical missionary work, *Curing Their Ills*, 74; while Rennick believes (following Adrian Hastings) that within her sphere of study, a much earlier date (late 19<sup>th</sup> c.) might be cited, *Church and Medicine*, 118; see Adrian Hastings, *The Church in Africa 1450 – 1950*, 177-178. I understand these latter two authors’ use of ‘secularization’ in association with increasingly specialized medical work, but wonder, from a missiological understanding, at how widely it can be applied to specific cases of medical work taking place within a missionary endeavour. Though semantics as well as specific job titles and duties can certainly be cause for severe problems and misunderstanding, as evidenced by the case of the dismissal of Neil Macvicar (‘mission doctor’, but not ‘missionary doctor’) from Blantyre (see chapter 3, above).

For more on the Victoria Hospital as a place for evangelism under Guinness’s superintendency, including reference to Lovedale evangelists coming to the hospital, see *Victoria Hospital Board, Lovedale Report for the Year 1940* (The Lovedale Press), 5; *Victoria Hospital Board, Lovedale Report for the Year 1941* (The Lovedale Press), 3-4; *Lovedale Hospital Board. Report for the Year 1942* (The Lovedale Press), 2. Dr A.F. Grattan Guinness resigned 18<sup>th</sup> November 1943, after which Mr W.C.J. Cooper, who had been staff Surgeon since 1938, and Acting Medical Superintendent since February 1942, ascended to the Medical Superintendency, which he held, *at least*, until 1950.

<sup>572</sup> For more on the training of nurses and medical assistants, see chapter 3.

area of training at the hospital. Missionaries preparing for their work were also prepared for their future labour with some instructional teaching and basic ‘hands on’ training at the hospital, and a system was set up to educate those that came into the hospital for longer periods of treatment, especially children.<sup>573</sup>

#### *Nurses and Medical Assistants*<sup>574</sup>

As demonstrated in chapter three of this thesis, one of the primary reasons for training up nurses was to enact wide ranging changes not simply in the treatment of ill health and sickness, but in trying to replace the traditional understandings of such things as disease causation. Both Macvicar and the Victoria Hospital planners before him believed that African nurses would be one of the most important professions to ‘enlighten’ the African population within southern Africa. In addition to the hope of changing world views and enhancing public health, these missionaries tried to re-order crucial African social systems, especially with regard to the practitioners of health. In a village where (for the sake of hyperbole) an elder male was the traditional doctor/herbalist/witch-finder, the system propagated by the hospital sought to change this on a host of levels: generational, gender, religious, training, and medical.

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<sup>573</sup> *Victoria Hospital, Lovedale, South Africa*. (n.p. [Lovedale]: [The Lovedale Press] n.d. [c. 1902]), Lovedale Box, AMKWT, 1. The third stated object of the hospital was thus stated: “To provide as far as may be practicable, a short course of training in elementary medicine and surgery for intending missionaries and others likely to benefit thereof.”

<sup>574</sup> See chapter 3 for more on the training of nurses. As the training of nurses at the Victoria Hospital has been analysed in other studies, and due to space constraints within this thesis, I can but briefly address this topic. See, Shula Marks, *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession* (New York: St. Martin’s Press, 1994).

For more on the education of medical assistants, see chapters 3 and 6.

Just as most medical doctors working in South Africa at the beginning of the 20<sup>th</sup> century were trained in Britain, and often Edinburgh, the senior nursing sisters serving in the largest South African hospitals were also trained in Britain.<sup>575</sup> Yet the Victoria Hospital's role in becoming the first and pre-eminent location for the training of African nurses (within South Africa), was met with mixed reaction. Many white nurses were threatened at the idea of black nurses being allowed to qualify and serve in an equal setting, and their active rejection of this cause even bifurcated opinions within the medical communities.<sup>576</sup> As such, this missionary aspect of training nurses and medical assistants is a notable example of a specific approach to medical mission work not simply going against certain segments of the professional society, but leading the way in broader public policy.<sup>577</sup>

#### *Training Missionaries in Basic Medicine*

Yet the instruction of African medical personnel was not the only training which occurred there. In a period about the time of the beginnings of the Union of South Africa, a few young Afrikaaner men went to Lovedale to prepare for their future career in missionary work (likely in Malawi).

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<sup>575</sup> Howard Phillip, 'Home Taught for Abroad', in *The Cape Doctor*, 113-118; 'The Training of Nurses in South Africa', *SAMR* 11, no. 11 (15 November 1904): 206.

<sup>576</sup> See, for example, the editorials in the *South African Medical Record*, which did not agree with the *South African Nursing Record's* opinion on the matter, though some arguments were resolved: 'The Trained Nurse's Association and the Medical Councils', *SAMR* 16, no. 1 (12 January 1918): 1-3; 'The Coloured Nurse and the "S.A. Nursing Record"', *SAMR* 16, no. 2 (26 January 1918): 17-19; 'Second-Grade Nurses', *SAMR* 16, no. 3 (9 February 1918): 33-35; 'Second-Grade Certificates for Coloured Nurses', *SAMR* 16, no. 4 (23 February 1918): 49-51; 'The Trained Nurses' Association', *SAMR* 16, no. 5 (9 March 1918): 68.

<sup>577</sup> As Shula Marks has pointed out, in 1948 there were less than 1,000 fully qualified black nurses in South Africa. In marked growth, this number had swelled to more than 175,000 by the turn of the century. Shula Marks, 'The Gender Dilemma in Nursing History: The Case of the South African Mine Hospitals', (Seminar delivered at Oxford Brookes University, December 2000), 2; online at: <http://www.nursing.manchester.ac.uk/ukchnm/publications/seminarpapers/genderdilemma.pdf>



Photo of Dr Neil Macvicar, centre, with four South African missionaries, and one Victoria Hospital medical assistant. The missionaries had been attending a medical training session at the hospital in preparation for mission work in central Africa.<sup>578</sup>

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<sup>578</sup> 1663/SH 032/H/B, AMKWT. Written on the back of the photo: "4 Dutch students who spent some time at the hospital training under Dr Macvicar". On a piece of paper taped to the back of this photo (obviously from a later date, but written by someone who was closely connected to the Hospital): "These were four Afrikaans (Dutch as was the term in those days) students who were training to be missionaries. They came to the Victoria Hospital, Lovedale, to learn some of the medical aspects of missionary work under the guidance of Dr Macvicar. They are: Back Row: Mr Brink, Dr N. Macvicar, one whose name I have forgotten, a hospital orderly. Front Row: Mr Strijdom and Mr Rousseau. Approx 1910-1912."

These missionaries were probably with the Dutch Reformed Church of South Africa, which had been involved in mission work in what was then termed British Central Africa, and later the Nyasaland Protectorate, since 1888.<sup>579</sup> Not long thereafter, the Rev. D.J. Brummer, with the Paris Evangelical Mission in western Zambia<sup>580</sup> took a course in Tropical Diseases that Macvicar offered for missionaries.<sup>581</sup> And in 1915, “the Rev. J.H. Rens spent weeks at the hospital while being tutored in tropical diseases.”<sup>582</sup>

During their stay at the Victoria Hospital, such men would have received training in a South African mission hospital which was, at that time, still rather unique. Others, such as the American Board’s hospital in Durban under J.B. McCord’s superintendency (and later named after him) while adequate establishments, were located in urban settings. Lovedale provided training in a location that was accessible, with many amenities, while also being in the midst of a largely rural population – as most South African medical missionaries would encounter when going north into the African interior. Macvicar, whose previous medical mission work was in Blantyre, Malawi,<sup>583</sup> also provided an experienced opinion on such conditions. To be sure, the Victoria Hospital’s impact was nowhere

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<sup>579</sup> Donald Fraser, *Livingstonia* (Edinburgh: Foreign Mission Committee of the United Free Church of Scotland, 1915), 30-31. Note Fraser’s attestation regarding the role of John Stephen – the Glaswegian shipbuilder and important backer of Scottish missions – in helping to begin this venture amongst South African Dutch Reformed ministers while on a visit to Stellenbosch. This is the same man who was heavily involved in medical mission planning and work at Lovedale, both in Dr Jane Waterston’s time as well as Dr Neil Macvicar’s beginning.

<sup>580</sup> Then called ‘Barotseland’.

<sup>581</sup> ‘The Victoria Hospital, Lovedale. Report for 1913’, *CE* March 1914; ‘Lovedale News’, *CE* April 1913, 60.

<sup>582</sup> ‘Victoria Hospital, Lovedale. Report for 1915’, *CE* February 1916, 30.

<sup>583</sup> Then called ‘British Central Africa’, and subsequently (1907) the ‘Nyasaland Protectorate’ or ‘Nyasaland’.

on the scale of something like the Livingstone Medical College in London,<sup>584</sup> nor did it intend to be. Yet it held similar aims: imparting basic medical understandings from a specialised source, new advances in medical knowledge and technique, and general opinion on the aims of such work to missionaries who might not otherwise encounter it.<sup>585</sup> Finally, though difficult, if not impossible, to measure, I believe it is worth noting one last element. With the medical training of nurses and hospital assistants going on, not to mention the then active Health Society and other Health courses being taken by Lovedale students during those years,<sup>586</sup> these short term missionary visitors were being heavily exposed to the well educated black Africans of Lovedale and the Victoria Hospital personnel, something they might not have otherwise encountered in another setting.<sup>587</sup> Such observation and interaction with well educated African students and medical workers would undoubtedly have uniquely impacted these missionary short-term trainees.

#### *The Victoria Hospital as School*

With Lovedale's strong standing as a pedagogical institution, it is not surprising that education held a small, but notable, role at the Victoria Hospital. In addition to the education of nurses and medical assistants and basic training for

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<sup>584</sup> Grundmann, *Sent to Heal!*, 105-107.

<sup>585</sup> Michael Worboys, 'The Colonial World as Mission and Mandate: Leprosy and Empire, 1900-1940', *Osiris* 15 (2001): 209.

<sup>586</sup> 'The Hospital, Its Work and Its Opportunities', *SAO* July 1916, 106-107. Health classes were taught at the hospital to both the theological as well as normal students. By 1916, 372 had passed this course of study. In addition, the Health Society, discussed more fully in chapter 6, had its head office at the hospital.

<sup>587</sup> As Macvicar noted in the 1930's – about 20 years later – there were some within the highest echelons of the South African *medical community* who, irrationally in his opinion, objected to the full training of black nurses, presumably on the racist belief that they were not as capable as white nurses. 'Victoria Hospital, Lovedale. Report for the Year 1935', *SAO* February 1936, 42-46. For a more revealing view on this particular episode, see Shepherd, *A South African Medical Pioneer*, 114-117.



missionaries, the hospital was also a place of non-medical, even elementary, education for some of its patients.

Much of this educational work resided in the realm of literary education, overseen in its earlier years by the hospital's 'Bible Woman', Mrs. Knox Bokwe (1927-1934), who also undertook (as her title implies) a central role in the religious/spiritual work as already mentioned earlier in this chapter. In her capacity as someone tied to 'Bible work', she likely encouraged patients to 'take up and read', which posed a problem for illiterate patients. In her brief report for 1929, after relating aspects of a more evangelical nature, Bokwe noted, "Young men are interested in learning to read. One who was in for six months left able to read and write. One little boy after two months is in the second primer."<sup>588</sup> In the report for the following year she again noted the importance of working with the children who were patients at the hospital and their work teaching them with the aid of Rev. R.H.W. Shepherd, minister of the Lovedale Institution Church, who supplied books and slates for their schooling.<sup>589</sup> In these earlier years of this educational work, teaching patients to read seems to have grown as an organic reaction to other issues, and not altogether specialised.<sup>590</sup>

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<sup>588</sup> *Report of the Victoria Hospital, Lovedale, 1929* (Lovedale Institution Press), Lovedale Box, AMKWT, 7.

<sup>589</sup> *Report of the Victoria Hospital, 1930*, Lovedale Box, AMKWT, 4.

<sup>590</sup> *The Christian Express* related a story, in a manner typical of its day, of at least one case of literacy work which was performed in a mission hospital at Mengo, Uganda: "Another was quite a young girl (a Heathen), who had given way to *bhang* smoking and was also suffering from fever. The poor girl was quite stupid from the effects of smoking, and could hardly answer when spoken to. We took her pipe away and kept a strict watch over her, and in a short time she got quite bright. We gave her the first reading sheet, and she made a real attempt to learn her alphabet, and listened attentively to all that was said to her." 'In a Central African Hospital', *CE* March 1900, 44. *Bhang* is also known as cannabis.

In a matter of just a few years, the hospital had instituted a much more organised pedagogical system.<sup>591</sup> By 1932 the Victoria Hospital was fully engaged in educating over fifty severely ill (“cripple”) children under the direction of a teacher, Mrs Zantsi. The system was even examined by the government’s School Inspector. These children, often sick with varying types of tuberculosis (such as spinal or bone), were in the hospital receiving treatment for such a long period that the hospital leadership apparently approached it as an opportunity to educate them. It was then believed that the children, some of whom would never physically fully recover, might have a better chance at finding future employment if they were literate.<sup>592</sup> Due to extensive construction in 1933, much of this education for sick children was disrupted, but the work carried on with the assistance of some of the Lovedale Institution’s student teachers.<sup>593</sup>

By 1934 the Hospital’s construction extension allowed for 175 beds, over seventy of which were occupied by the “cripple children”. In addition to their treatment for TB, grounded in part on the “open-air and sun treatment” out on the new veranda, as well as a healthier diet, the children continued to be taught how to

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<sup>591</sup> The close association between medical work and more formalized school for children was also uniquely seen at the Mildmay Medical Mission in Hebron, Palestine. Its success was something which the missionaries believed was due to the fact that the school was *in* the Medical Mission, not separated from it. See, ‘The Medical Mission at Hebron’, *CE* July 1900, 106.

<sup>592</sup> ‘Victoria Hospital Report, Lovedale, 1932’, *SAO* February 1933, 37. Note the similarity between this approach and that found in the leprosy work of fellow Scot medical missionary, Dr. A.B. Macdonald at the Itu Leper Colony. Part of Macdonald’s approach to medical missionary work in Nigeria was to prepare the long-term patients with certain skills, such as literacy, not simply for religious reasons (i.e. to read the Bible), but for making a living within the colonial system when they released.

<sup>593</sup> *Victoria Hospital, Lovedale. Report for the Year 1933* (Lovedale Press), 5-6.

read.<sup>594</sup> Macvicar believed that due to their weakened physical condition they would not be able to take up any sort of manual labour, which was such a common characteristic of rural African work, and that a low paid job as a tutor to other children would be better than nothing.<sup>595</sup> In 1935, Zantsi left and was replaced by Mrs H. Msutu (1935-1937), who stopped working at the hospital at the same time as Dr Macvicar. With the Bible and hymns taught as part of their literary learning texts and an emphasis on industrious individual effort, such an approach to this schooling aspect of the hospital's work might correctly be seen as Western, if not Scottish, in its approach. And indeed, this aspect of the hospital operating as a school can be rightly seen as part of the wider aim of inculcating patients with 'civilising' ways. As one young female patient, who had never before been to school, reportedly related to a new patient coming in to the Macvicar Tuberculosis Hospital at Lovedale for treatment: "And I have learned to read at the hospital school and I am taking home with me a Sub B reader and a Bible, for I don't want to go back to the old heathen ways."<sup>596</sup> Such comments were surely music to the ears of both missionaries and their supporters back home.

### ***Concluding Remarks***

Under Macvicar's Superintendency, the Victoria Hospital itself enjoyed a period of relatively steady expansion, especially when one considers the period and

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<sup>594</sup> This treatment method was the norm through much of British colonial Africa (in terms of Western medical methods), H.V. Morgan, 'Tuberculosis', in *Health in Tropical Africa During the Colonial Period*, ed. by Sabben-Clare, and others, (Oxford: Clarendon Press, 1980), 80.

<sup>595</sup> *The Victoria Hospital, Lovedale. Report for the Year 1934*, Lovedale Box, AMKWT, 3.

<sup>596</sup> D.W. Semple, *A Scots Missionary in the Transkei* (Lovedale: The Lovedale Press, 1965), 73.

its difficulties, resulting in over 150,000 African patient attendances by the end of his tenure.<sup>597</sup> With this stable pattern of growth, it provided a solid foundation for future development in the years after his retirement (which expanded a great deal, including the 100 bed Macvicar Tuberculosis Hospital, which opened in 1940), a far cry from the state of medical mission work at Lovedale when Macvicar arrived. Yet as the centre of his medical practice for black South Africans, his emphasis upon the hospital as the location of medical treatment inevitably limited his interaction with locals within their personal spheres and locations of everyday life. Indeed, this hospital-centred method was a vital aspect of his approach to medical missionary work. To his manner of thinking, the Victoria Hospital epitomised the highest level of Western biomedical treatment – curative and palliative – typical for its period.<sup>598</sup> And situated in the rural setting, the hospital was surely viewed, at least by the missionaries, as a kind of medical station upon a hill, emanating the bright light of Western biomedical standards.<sup>599</sup>

From its earliest days, the Victoria Hospital aspired to spread, “chiefly among the natives, a better knowledge of personal and domestic hygiene and the care of the sick,” a kind of health propaganda, as well as tending to spiritual matters for the patients.<sup>600</sup> It was this religious aspect of the hospital which helped shape some of the missionary perceptions of their place of work. While sacred spaces may not have

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<sup>597</sup> Neil Macvicar and D.A. Hunter, [“Letter Seeking Monetary Support”], single page, typed copy document, [1929], MS 16,457 LC CL

<sup>598</sup> Marcos Cueto, ‘The Origins of Primary Health Care and Selective Primary Health Care’, *American Journal of Public Health* 94, no. 11 (November 2004): 1864.

<sup>599</sup> Shepherd, *Lovedale South Africa 1841-1941*, 360.

<sup>600</sup> *Victoria Hospital, Lovedale, South Africa*, [n.p., n.d.], 1. AMKWT, Lovedale box. This little 11 page pamphlet was almost certainly published at Lovedale, and probably circa 1898.

always been inviting or friendly spaces for many Africans, the missionaries presented the Victoria Hospital in terms that rendered it rather church-like. With austere surroundings as well as a quiet and ordered atmosphere, the hospital harboured a strong resemblance to many Scottish Presbyterian churches. And indeed the Victoria Hospital operated as a place for evangelism and spiritual conversation. While not an evangelical Christian himself, Macvicar prayed with both patients and staff and was not shy to speak about spiritual matters. More than this, however, is the importance in recognising that he allowed other figures, such as the biblewoman Maria Knox Bokwe, to play prominent roles in establishing and conducting more typically evangelistic functions within the hospital. In this way, his broader approach to medical mission work allowed for a wide array of input on Christian matters at the hospital, while he himself concentrated on the medical work and not trying to ‘convert souls’.

In other manners of its function during this period, the Victoria Hospital is especially notable as a centre of learning and training. Macvicar’s idea of conversion as a wholesale adoption of scientifically-based understandings of health matters and Christian-based understandings of ethical norms combined in this element of the hospital’s function as a place of instruction: “The School may be said to be the instrument of *Light*, enlightening the darkness of the heathen mind, and the Hospital the instrument of *Love*, by which *Love* comes into touch with the actual lives of the people”.<sup>601</sup> Utilising the hospital as a schooling centre to teach children and adults as well as a training centre for missionaries to learn more about matters of health further demonstrates the broad understanding of what ‘medical missionary work’ actually

encompassed for Macvicar and the other Victoria Hospital personnel. And once again, while Macvicar was engaged in his area of medical expertise with the health training for missionaries, African women like Bokwe and Zantsi were empowered in their roles running hospital-based education programs for patients.

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<sup>601</sup> Macvicar, 'The Place and Aim of Medical Missions in South Africa', *CE* August 1904, 17.

## **Chapter 5: Surgery, Disease, and Ill Health, with particular emphasis on the 1918 Influenza Pandemic**

### **Introduction**

In the previous chapters I have covered aspects related to the medical history of the Lovedale Mission, centred especially on some of the key participants in this endeavour and the rise of the Victoria Hospital. Chapter four focused on some of the capacities in which the hospital functioned, including its role as a training centre for missionaries, location of learning for children and adults alike, and site of religious influence. In this chapter I turn attention to the inter-related subjects of disease, sickness, and ill health.

One of the themes I have brought out in this thesis is the notion of Macvicar's triumphalist tone and attitude toward modern Western scientific thinking and how this mindset affected and informed his approach to medical missions, theology, and confidence in biomedicine and education. With particular regard to matters of disease, Macvicar was generally optimistic in his outlook on what he perceived to be the ever improving advances in medical science to treat disease, even while the social and health conditions of the black South African population were largely worsening. This conviction was well stated in an address he gave to the Ciskei Mission Council just a few years after his retirement from Victoria Hospital:

After all, medical science itself is young. It is only in the last couple of generations that firm evidence has been obtained of the actual nature of many diseases, and until that had been discovered, efforts to relieve and cure, not to say prevent, many diseases were ineffective, even sometimes harmful. But, now that the twin sciences of medicine and surgery have emerged from their dark ages and are rich with blessings for mankind, it only remains to apply the knowledge they have gained. In all civilized countries, through hospitals, clinics, school-teaching and literature, the people are getting help in sickness and guidance in health. It is a privilege to be alive in this time of enlightenment and of triumph over disease and suffering. It is a

double privilege to be permitted in a country as yet only partly Christian to minister these blessings to people whose need for them is so great.<sup>602</sup>

There is no doubt that the medical advances and knowledge of healthcare-related issues were indeed incredible during 19<sup>th</sup> century. But while his opinion reflects the optimism in the scientific advances in medical understandings of health and disease, the reality is that some biomedical remedies were thought better than they actually were, surgical procedures were still relatively pioneering, and other treatment plans – as many still are today – were educated conjectures at best.<sup>603</sup>

## ***Surgery***

In the wake of advanced understandings of human anatomy, bacteriology, and causes of infection during the 19<sup>th</sup> century, surgery was becoming both ever more sophisticated and routine within the realms of European and North American medical practice. With Joseph Lister's advances in antisepsis and asepsis from the late 1860's and earlier progress with anaesthetics, such as chloroform, the realm of surgery opened up much greater possibilities for successful medical treatments.<sup>604</sup>

This particular skill, in the mind of many missionaries, offered opportunities for the

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<sup>602</sup> Neil Macvicar, 'Native Health: General Survey and Hospitals', in *Native Health*, 1-2.

<sup>603</sup> This is not to say that Macvicar was blindly extolling the advances of Western biomedicine and understandings of health, without acknowledging contemporary limitations. See, for example, Macvicar's recommendation that individuals with epilepsy resign themselves to life at home, or his self-proclaimed acknowledgment of the medical community's ignorance about botulism and other elements of nutrition: 'Food Values. -I.', *SAHSM* April 1930, 1; 'Notes on Food Preservation and Food Poisoning', *SAHSM* July 1930, 5; 'People with Epilepsy', *SAHSM* January 1931, 6.

<sup>604</sup> This period was still riddled with many elements from previous procedures: Lister, for instance, did not thoroughly wash his hands, though rinsed them with carbolic acid and still wore his street clothes in surgery. For more on this period of surgical history, see Roy Porter, *The Greatest Benefit to Mankind* (London: Fontana Press, 1999), 360-374, 597-627.



movement of such practices to the outer realms of Western hegemony. Time after time in the discourse – from their viewpoint, and (according to them) often in the opinion of the people they sought to ‘cure’<sup>605</sup> – no other aspect of the missionary physician’s repertoire was as impressive as surgery.<sup>606</sup> In a short article in his denomination’s missionary magazine, the Rev. George Douglas epitomizes the multi-sided benefits missionary medicine believed it provided, while he extolling the virtues of surgeons more particularly, “One wonders whether it is realized in the Home Church how exceptionally expert our medical missionaries become in their own profession on the foreign field, especially in surgery”. After recounting what he considered a dire health climate in China, Douglas went on:

To whom can such poor sufferers go for relief other than the mission doctor? There is no one else competent to help. Their own medicine men – native “doctors” so called – will go any length in imposing upon the credulous *in extremis* for gain, concealing their own ignorance with a brave show of worthless drugs and needles and plasters, with which they often do a lot of harm. But fortunately, when it comes to surgical work, the native doctor has usually sense enough to refrain from the too reckless use of the knife, having a wholesome fear of possible consequences in the law courts.

The result is that when tumours and cancerous growths have to be excised, and ulcers and neck glands, and stones and gunshot wounds and the like come to be dealt

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<sup>605</sup> As another voice on this matter, note the dissenting (non-missionary) medical observation of Michael Vane, a white South African surgeon and medical officer of mine hospitals in the Transvaal at the Oriel mine, beginning in the early 1930s. In his words regarding this period, “South African natives in general do not like operations. In this respect I felt sympathy towards them, and it was generally understood at mine hospitals that the knife would not be used unless its use was unavoidable.” Michael Vane, *Black Magic and White Medicine* (London: W. & R. Chambers Ltd., 1957), 66.

<sup>606</sup> For missionary examples, see: in China: Harold Balme, *China and Modern Medicine: A Study in Medical Missionary Development* (London, United Council for Missionary Education, 1921), 89-90; Dugald Christie, “Two Varieties of “Thrills”, *Other Lands* 11, no. 42 (January 1932): 43-44; in India: *Medical Missions* (Edinburgh: Edinburgh Medical Missionary Society, 1874), 76, 117; in Arabia: P.W.R Petrie, ‘A Lonely Outpost’, *Other Lands* 11, no. 42 (January 1932): 49; in Africa: Chauncy Maples, in *Chauncy Maples*, Ellen Maples Cook (edit. and intro), (London: Longmans, Green, and Co., 1897), 359.

Note the alternative tone in some missionary discourse, however, which did not accredit particular successful surgeries to wholly Western medical acumen, but to God’s working amidst or beyond their biomedical expertise. See, for example, the account from the Women’s Hospital in Kaiyuan, northeast China (formerly referred to as Manchuria): Jean McMinn, ‘A Patient’s Gallant Fight’, *Other Lands* 13, no. 50 (January 1934): 49.

with, and crushed limbs require amputation, and skulls are cracked and eyes go blind with cataract, the mission hospital and the foreign doctor are the only resort.<sup>607</sup>

Douglas' assessment of the situation, while typical of Western opinions on the inefficacy of non-Western medical practices, more importantly display the unique place surgery held in missionary medicine.

Although Macvicar was trained in medicine and not as a Surgeon, as the sole physician of the mission, his work encompassed surgical procedures.<sup>608</sup> Such solitary ventures very often called for expanded professional responsibilities, and Lovedale was no exception.<sup>609</sup> One relatively common surgical procedure undertaken at the Victoria Hospital was for cataracts. Although replete with Christian symbolism (a facet that was sometimes taken up in the missionary discourse<sup>610</sup>), the actual process of bringing physical sight to those who had been partially or totally blind, was undoubtedly a rather extraordinary achievement. In his first full year at Victoria Hospital (1903), Macvicar performed a total of eight cataract surgeries, all of which were successful, according to his reckoning. The following year he performed thirteen, with two "failures". By the beginning of October 1905, he had already performed eighteen surgeries, all of which were

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<sup>607</sup> George Douglas, 'Young Surgeons – Go East!', *Other Lands* 9, no. 35 (April 1930): 82.

<sup>608</sup> Another surgeon, Dr Hobart, had been employed at the hospital nearly a decade after Macvicar's arrival, but it was deemed that there were an inadequate number of surgeries demanding the presence of a surgeon at that time.

<sup>609</sup> This was not uncommon, even outside missions; Elizabeth van Heyningen, '“Regularly Licensed and Properly Educated Practitioners”: Professionalisation 1860-1910', in *The Cape Doctor*, 297-299.

<sup>610</sup> For example, the brief excerpt from the American Episcopal missionary magazine, *Spirit of Missions*: "St. James's Hospital, Nanking, is treating many cases of blindness from cataract... Recently an operation was performed on a woman slightly past middle age, who went home cured. A few weeks later a sweet-faced old lady, nearly eighty, who had been totally blind for twenty years, was led to the hospital.... and in due time the old lady went home as happy as her daughter. Thus the

successes,<sup>611</sup> yet went on to perform dozens more in the remaining few months.<sup>612</sup>

While relatively small, numerically speaking, these large percentage increases seem to clearly indicate local African receptiveness to the procedure during these early years after the hospital's re-opening.



“Interior theatre” in the Victoria Hospital. The photo shows a well organised and clean room, with examination/operation table on left, physician's stool in the middle, and accompanying utensils and tools on the table on the right and against the back wall.<sup>613</sup>

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blind led the blind, and both found light. Perhaps, too, some desire for light for blind souls has been aroused in them.” Quoted in *CE*, July 1904, 107.

<sup>611</sup> Neil Macvicar, Lovedale, to D.A. Hunter, 6 October 1905, ‘B’, PR 4150, LC CL.

<sup>612</sup> In this report, Macvicar wrote that he had performed seventy-six operations, with the majority of these being eye operations. The difference between 18 by the end of September and perhaps 50 or 60 by the end of the year leads one to believe that the definitions used between these two sources were referring to different aspects of surgery: perhaps minor more major surgical treatments. Neil Macvicar, ‘The Victoria Hospital’, *CE* January 1906, 5.

<sup>613</sup> 1674/SH 032, AMKWT. Accompanying notes to photo: “Interior of Theatre, Victoria Hospital, Lovedale. No date”.

Throughout his active career in medical practice, only a small portion of Macvicar's work was found in the surgical ward, and this is not surprising, given his other interests and responsibilities. While eye surgeries continued to be a mainstay of his surgical case load,<sup>614</sup> sometimes even meriting attention in scholarly medical journals,<sup>615</sup> prior to 1927 they never amounted to more than 100 cases in a year.



Male surgical ward of the Victoria Hospital, 1936. Eight beds are clearly visible, all occupied, with one of the Victoria nurses, at her station in the centre of the room. The bed in the foreground looks to be occupied by a child. Note that flowers are the only accessories.<sup>616</sup>

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<sup>614</sup> In 1915, for example, eye operations accounted for 26 of the 63 operations performed. Four years later, with 92 operations undertaken, 21 were for cataracts. See, CE February 1916, 30; February 1920, 28.

<sup>615</sup> Neil Macvicar, 'Trichiasis following Herpes', *SAMR* 8, no. 2 (22 January 1910): 20.

<sup>616</sup> 1662/SH 032/H/B, AMKWT.

With the arrival of Dr Shena Macvicar on the Hospital staff as Surgeon in that year, the number of surgical cases dramatically increased, rising to an average of over 250 operations per year in the late 1920s and early 30s, and to over 300 operations per annum in the years thereafter.<sup>617</sup>

More interesting than the methods of healing performed by the mission hospital, however, may be the lack of attention paid to surgery by Macvicar himself, especially within the typical missionary discourse. It could be that the familiarisation of surgical methods and operations had lost a certain amount of uniqueness for the wider South African and Scottish supporting missions (these were the main recipients of Lovedale's publication on the matters), and therefore did not merit, in his view, extra attention. Rather, it seems that surgery was increasingly put to the side, not in actual performance, as the numbers clearly demonstrate African reception to this method of healing especially during Shena Ross's time at the hospital, but in favour of Macvicar's attention to other concerns, such as public health measures, or the realities of the rural black African health climate. The lack of attention to the surgical work performed at Victoria Hospital lies in direct juxtaposition to Macvicar's growing concern with governmental policies on health and the spread of disease, or continued attention to African traditional conceptions of healing and disease causation.

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<sup>617</sup> Shena Ross (nee Macvicar) resigned, along with her husband, Dr Richard Ross, the Assistant Medical Officer of the Victoria Hospital (1929-1937), and her father, Neil Macvicar, in 1937. She married Ross in 1928.

## **Professional Scholarly Contribution**

During the 19<sup>th</sup> and early 20<sup>th</sup> centuries, missionaries – medical and non-medical alike – contributed to the wider arena of European scholarly work on myriad subjects. Reports from their locations on the ‘fringe’ of colonial domain or expansion (and beyond) were eagerly consumed by common readers and scholars alike. Amongst other portions of his work, the famous David Livingstone was widely regarded as a missionary-explorer and his accounts of uncharted portions of central Africa caused the Royal Geographical Society to repeatedly print his literary output.<sup>618</sup> Other journals, such as the *Botanical Gazette*, or the wonderfully named (especially for this period), *Bulletin of Miscellaneous Information (Royal Gardens, Kew)*, gleaned and reported information on new plant species from missionary

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<sup>618</sup> A few of these include: David Livingstone, ‘Explorations into the Interior of Africa’, *Proceedings of the Royal Geographical Society of London* 27 (1857): 349-387; David Livingstone, John Kirk, and T. Baines, ‘Extracts from the Despatches of Dr. David Livingstone, M.D., Gold Medallist R. G. S. (Dated December 17, 1858; February 14, May 12, July 26, and October 15, 1859) to the Right Honourable Lord Malmesbury’, *Journal of the Royal Geographical Society of London* 31 (1861): 256-296; Charles Livingstone, David Livingstone, H. de Wint Burrup, ‘Dr. Livingstone’s Expedition to Lake Nyassa in 1861-1863’, *Journal of the Royal Geographical Society of London* 33 (1863): 251-276; David Livingstone, ‘Letters from the Zambesi to Sir R. I. Murchison, and (The Late) Admiral Washington’, *Proceedings of the Royal Geographical Society of London* 8, no. 6 (1864): 256-263; David Livingstone, ‘Explorations to the West of Lake Nyassa in 1863’, *Journal of the Royal Geographical Society of London* 34 (1864): 245-251; David Livingstone, ‘Letter’, *Proceedings of the Royal Geographical Society of London* 11, no. 1 (26 November 1866): 15-18.

Note the wording of Count de Lavradio’s toast at Livingstone’s farewell party, before his Zambesi Expedition: “I have full confidence that the new explorations of Livingstone will have great results for science, commerce, and the civilization of Africa.” Here, the well-known use of ‘Christianity’ within the three ‘Cs’ (commerce and civilization rounding out this trinity) had been replaced with ‘science’, and emphasized not what would be given to Africa, but what will be gleaned from it. ‘The Farewell Livingstone Festival’, *Proceedings of the Royal Geographical Society of London* 2, no. 2 (13 February 1858): 120.

While Livingstone’s work may have been received with interest in the geographical realm, there was a cool, often sharp, and sometime hypocritical review given to his second work, *The Zambesi and its Tributaries*, by one leading anthropological journal, which remarked at one point, “Anthropologists find little in this work to notice except some serious blunders, which we shall presently expose. On the other hand, we can cordially recommend it to all nigger worshippers, missionary exporters, and other Exeter Hallitarians”. ‘Livingstone as an Anthropologist’, *Anthropological Review* 4, no. 13 (April 1866): 143-149 (quote: 144-145).

sources in foreign lands.<sup>619</sup> Patrick Harries has recently done substantial and important work on this topic on the role of Swiss missionaries in southern Africa and their contribution to wider discussions, interpretation, and thought on such subjects as natural science, anthropology, and language.<sup>620</sup> Of course, in addition to these other arenas, medical missionaries were most helpful to the broader academy for their opinion and observations in the regions of medical related scientific knowledge.<sup>621</sup> And in this regard, Macvicar, and occasionally other Lovedale medical personnel, contributed to the professional and academic realm.

The rise in the study of tropical medicine during the last few decades of the 19<sup>th</sup> century was a key aspect of the Western powers' expansion of their imperial growth. To 'tame' these foreign lands, tropical illnesses – a barrier affecting people, trade, war, etc. – were confronted through scientific inquiry and study. Such efforts were seen as of paramount importance in the struggle.<sup>622</sup> One of Macvicar's patterns, in this regard, was his occasional but steady contribution to medical journals on particular case studies he encountered during his medical career.

#### *Macvicar's Scholarly Contribution*

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<sup>619</sup> 'The Square Bamboo', *Botanical Gazette* 12, no. 1 (January 1887): 18. The information related here came from the medical missionary, Dr Macgowan, who had worked in China. 'Economic Plants of Madagascar', *Bulletin of Miscellaneous Information (Royal Gardens, Kew)* (1890): 200-215. Note the mention of Dr R.W. Parker, a medical missionary to Madagascar who had compiled a Malagasy Materia Medica and relayed his findings back to Britain.

<sup>620</sup> See *Butterflies and Barbarians: Swiss Missionaries & Systems of Knowledge in South-East Africa* (Athens, Ohio: Ohio University Press, 2007); 'Field Sciences in Scientific Fields: entomology, botany, and the early ethnographic monograph', in *Science and Society in Southern Africa*, ed. by Dubow, (Manchester: University of Manchester Press, 2000), 11-41.

<sup>621</sup> See, for example, 'The Prevailing Fevers of China', *Science* 17, no. 437 (19 June 1891): 338.

<sup>622</sup> Porter, *The Greatest Benefit to Mankind*, 462-487.

In an article which was submitted between his time at Blantyre and Lovedale, Macvicar contributed a piece on snake poisoning to the London based *Journal of Tropical Medicine*, a publication which had started in 1898.<sup>623</sup> With fastidious notes on a few cases of snake bites during his time at Blantyre, the missionary supplied medical annotations and analysis – such as patient complications, medical treatments employed, and recommendations – with a bit of insight into local understandings of one type of snake:

The snake was said to be the ‘nsongo’ (Yao language) or ‘mbobo’ (Mang’anja language). Unfortunately I could not procure it. This ‘nsongo’ is, however, generally regarded as rather mythical. Natives say of it that “it crows like a cock,” but when pressed, they admit that they have never seen it. This patient, however, says quite decidedly that he was bitten by an ‘nsongo’.<sup>624</sup>

Holding to the medical parameters of the journal, Macvicar unfortunately neither commented further on this element, nor did he provide African remedies for snake bites.

Macvicar’s other scholarly contributions to the medical arena, which in and of themselves could be viewed as particular case studies and therefore seemingly insignificant articles,<sup>625</sup> do in fact sometimes provide socio-cultural and medical missionary insights. In a brief little article on a patient with malaria (an unusual condition within the region), Macvicar provided typical medical commentary. But he also wrote that the worker had recently returned to the Victoria East district from

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<sup>623</sup> Neil Macvicar, ‘Snake Poisoning in Central Africa’, *The Journal of Tropical Medicine* 5 (1 January 1902): 1-3.

<sup>624</sup> *Ibid.*, 2. In D.C. Scott’s dictionary, *mbobo* is defined: “A long grey snake; it has a black crest”. David Clement Ruffelle Scott, *A Cyclopaedic Dictionary of the Mang’anja Language* (Edinburgh: Printed for the Foreign Mission Committee of the Church of Scotland, 1892), 331.

For another very brief contribution by Macvicar, in a missionary magazine, on snake poison (as well as Kembe arrow poison), see ‘Medical Notes’, *LWBCA* 114-118 (August-December 1897): 9-10.

<sup>625</sup> Neil Macvicar, ‘Case of Inversion of the Uterus’, *SAMR* 10, no. 3 (10 February 1912): 44; ‘Irido-Cyclitis as a Complication of Typhus Fever’, *SAMR* 15, no. 13 (8 December 1917): 357.



a copper mine in Upington in the Northern Cape region.<sup>626</sup> It is too much to assume that the patient had not sought or applied other African traditional methods of healing, and without wanting to take too much from this particular example, it is nevertheless telling that the man sought treatment at Victoria Hospital. It may well demonstrate the hospital's draw to those Africans with greater income, or possibly reveals that individuals with a greater familiarity with Western practices, both medical and otherwise, were more apt to patronize mission hospitals.

As Macvicar was one of a small minority of white South African medical practitioners treating black Africans within the rural setting, his contributions to medical journals were perhaps even more notable for their provision of knowledge to the more sheltered mainstream audience of urban white doctors treating white patients within South Africa (and certainly beyond). In this regard, some of his articles in the 1920s and early 1930s demonstrate his attention to what Welcome Zondi has called the 'disease environment',<sup>627</sup> and what I call the related 'health climate' within the wider black South African population,<sup>628</sup> as opposed to more restricted case studies.<sup>629</sup> One article on the dental conditions of girls beginning their schooling at Lovedale sought to contribute to the wider study going on at that time

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<sup>626</sup> Neil Macvicar, 'Malarial Fever in the Cape Colony', *SAMR* 7, no. 14 (25 July 1909): 187-188.

<sup>627</sup> Zondi, *Medical missions and African demand in Kwazulu-Natal*, 15-16, 92-129. For a brief account of the health climate and related factors within the region of the 'Ciskei region' from a number of missionary responses on the issue, see, 'The Health of the Ciskeian Native Population', *SAO* December 1927, 227-228 (possibly written by James Henderson, the Principal of Lovedale).

<sup>628</sup> See his overarching work on disease, treatment, and other responses to the health climate: N. Macvicar, 'The Prevalence of Certain Diseases among the Natives of the Ciskei', *SAMJ* 6, no. 22 (26 November 1932): 721-724.

<sup>629</sup> Of course, particular case studies are sometimes written for the very purpose of demonstrating not their uniqueness, but their commonality to wider endemicity. See, for example, Neil Macvicar, 'An Epidemic of Mixed Varicella and Herpes', *JMASA* 4, no. 13 (12 July 1930): 390. His clinical notes provide specific examples of female cases from the Lovedale Girls' School, while also briefly mentioning incidence in black communities outwith Lovedale.

on factors which led to the health conditions of South African children.<sup>630</sup> Another piece on the incidence of cancer, based on his experience in treating about 10,000 in-patients during his tenure while at the Victoria Hospital, provided statistics related to forms of cancer, gender, age, etc. It also offered his intriguing postulations regarding the cause of certain cancers. Modern medical thought would agree with his conclusion that tobacco contributed to cancer of the mouth, but would have a much more difficult time acceding to his deduction that corsets were the cause of breast cancer amongst some African women:

Cancer of the breast is rare. I am inclined to attribute this immunity to the fact that in their natural state Bantu women do not wear corsets, and rarely do so even when adopting other European clothing. The few who did wear the high-ribbed corset of last generation seem to have suffered as commonly as Europeans from cancer. Two of the six cases mentioned had been corset-wearers, and I remember a third, an out-patient. In one other case (in-patient) the origin was clearly traced to the pressure of a cord, which crossed the upper part of the breast, and from which a garment was suspended. The cancer began exactly under the mark made by the cord.<sup>631</sup>

Indeed, to most modern Western medical personnel Macvicar's conclusion here would be as difficult to believe as he himself found most African conclusions regarding disease causation.

While not providing any breakthroughs on these specific subjects, such involvement in the medical profession's discussions of the day clearly demonstrates an approach to medical mission work which reached beyond the borders of the mission itself, and sought to be a part of the wider medical and public health arena.

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<sup>630</sup> Neil Macvicar, 'Condition of the Teeth in Native Adolescents', *SAMR* 23, no. 1 (10 January 1925): 11. See also, Maughan Brown, 'The Condition of the Teeth of Children in the Cape Province', *SAMR* (September 1924). Brown had arranged some of his results relating to water conditions – hard vs. soft – while Macvicar arranged his on the lines of home altitudes, echoing his earlier work on the incidence of tuberculosis as well as factors related to food supplies and diseases such as scurvy.

<sup>631</sup> Neil Macvicar, 'Notes on Cancer among the Native People', *SAMR* 23, no. 14 (25 July 1925): 315-316.

### *Higher Education Contributions*

In addition to articles and papers put forth before medical societies, both Neil and Shena Macvicar submitted theses for their Medical Doctorate degrees at the University of Edinburgh on research related to disease in South Africa. Neil Macvicar's work on tuberculosis helped cement his professional standing on the issue within the South African health community.<sup>632</sup> Shena Macvicar had studied at Lovedale, and from 1916-1919 was an assistant teacher in the Normal Department.<sup>633</sup>



Photo of girls and young women at Lovedale, probably Practising School students, with Miss E.M. Weaver, in the foreground (right), and Miss D.K. Griffiths in the centre (rear), c. 1910. Shena Macvicar is in the line on the right side of the picture, probably the second girl from the right.<sup>634</sup>

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<sup>632</sup> Neil Macvicar's work on tuberculosis is discussed in the 'Tuberculosis' section below.

<sup>633</sup> 'Lovedale Staff 1911-1920, taken from Annual Reports', Lovedale Box, AMKWT, 4.

<sup>634</sup> 11956/SH 147, AMKWT. The accompanying text for this photo reads: "At Girls School, Lovedale" "Betty Henderson, Miss Weaver, Irene Fowler.... Nancie Smith, Cathie Fowler, Shena Macvicar, Winnie McPherson, Miss Griffiths", with the names associated with physical locations on

Thereafter she left for Scotland, obtaining her M.B. Ch.B. at the University of Edinburgh in 1924, becoming a Fellow of the Royal College of Surgeons, Edinburgh, in 1927, and completing her M.D. thesis for the University of Edinburgh in 1929.

While quite succinct, her thesis on scurvy was reflective of the severe climatic conditions of the period,<sup>635</sup> and its impact in turn on the longstanding local health climate. This 'deficiency disease'<sup>636</sup> had garnered the attention of her father due to its near endemic presence amongst the local African population, as well as workers in the mines and cities, during his decades at Lovedale.<sup>637</sup>

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the back of the photo. I have dated this photo to 1910, as this is the only year in which both Weaver and Griffiths were listed on the Lovedale Staff at the Practising School, and corresponds to Macvicar's general age in this photo. See, 'Lovedale Staff Papers, Taken from Lovedale Reports', AMKWT, Lovedale Box, 4.

<sup>635</sup> The drought ran from 1927 through 1928, and the Victoria Hospital had 154 in-patient admissions for scurvy, along with 79 for 'debility' (diet deficiency related sickness) in 1928, a total of 233 cases. This compares with 23 cases of scurvy and 21 cases of debility for the year 1926. This is effectively a 475% increase between pre-drought conditions and at the height of the prolonged drought. 'Report of the Victoria Hospital, Lovedale, 1928', *SAO* February 1929, 29; 'Report of the Victoria Hospital, Lovedale, 1926', *SAO* February 1927, 31.

Note Macvicar's informative description and analysis of the situation during an earlier extended drought – and the 'prophetic' words spoken regarding similar future hardships. He called for no less than extensive structural social changes: "The experience of the past year raises once again certain grave questions. With an increasing population on a limited area of land, and that land mainly pastoral and subject to periods of drought, unless improved methods are introduced future years are likely to see still worse distress than this year has witnessed. The problem is one of extreme difficulty. There is no panacea. But it will have to be faced. The hereditary methods of a primitive people will have to become less primitive, casual neighbourly assistance will have to give place to a more organised social system by which food can be made to go round." 'The Effects of the Long Drought Upon the Health of the Native People', *CE* January 1916, 5-6.

<sup>636</sup> Scurvy was not the only deficiency disease affecting the local population due to dietary nutritional insufficiency; pellagra and beriberi were also present. Pellagra is a sickness caused by niacin (vitamin B3) deficiency, while beriberi is caused by a diet lacking vitamin B1 (also known as thiamine). A sadly ironic case of high morbidity of deficiency disease concurrent with the developments in eastern Cape Colony due to drought was the rise of deficiency disease in the American south due to flooding, though also occurring with great mortality amongst the poorest of the population. 'Pellagra Epidemic Threatens', *The Science News-Letter* 12, no. 334 (3 September 1927): 147-148.

<sup>637</sup> Neil Macvicar had provided a rather notable contribution to the South African medical community in his own right during the early years of the century. At that time the Cape Colony Medical Officer of Health, Dr A.J. Gregory, speculated that the disease was probably different from the well-known scurvy, and there was even discussion about the actual or varying causes of the disease. It was

Shena Macvicar's thesis was based upon research carried out at the Victoria Hospital.<sup>638</sup> Her work described the desperate situation many rural Africans within a drought plagued region encountered in this disease, (*umtshetsha* in Xhosa):

Thus it may be seen that even in normal circumstances the Natives' diet is not rich in anti-scorbutic elements, while in drought conditions they have to struggle along on maize and beans only. Almost every man, woman and child in time of drought has scurvy in some degree or other and bad cases are frequent. Infants at the breast are better off than most but if the mother has been without anti-scorbutic diet for some months her child seems to be poorer in vitamin content than normal and the child may develop symptoms. (vide Case 27). Children who have just been weaned – i.e. from one to three years, suffer badly. Being fed entirely on maize meal porridge and maize water they rapidly develop symptoms of infantile scurvy (extreme oedema, anemia, weakness and dysenteric diarrhoea). The death-rate amongst cases in hospital has been highest in this class. Men coming from the labour centres provide the best examples of adult scurvy, typical cases, unable to walk, with legs swollen and acutely painful from haemorrhages into the muscles and under the periosteum, fungating gums and loose teeth.<sup>639</sup>

Her thesis also tells of treatments for scurvy patients employed by the hospital.

Many of these were quite typical, though others might be seen as peculiar – if not completely inappropriate – through the eyes of modern science: lemon juice as a remedy for bronchitis, giving brandy as medicine to a six year old, and finally, administering varying levels of lemon and orange juice along with brandy, Digitalis, and Strychnine (hypodermically) to an 18 month old patient.<sup>640</sup> Mistreatments notwithstanding, her work nevertheless demonstrates a continued academic

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certainly so foreign to Macvicar's realm of typical diagnoses that he mistreated an early case. See, Neil Macvicar, 'Notes on Scurvy', *SAMR* 4, no. 7 (25 April 1906): 101-103. See also his comments and judgments, especially regarding the usefulness of wild herbs, etc. in the "Red Kaffir" female diet as more beneficial than the "Christian natives": Neil Macvicar, 'Notes on Scurvy and Allied Conditions', *SAMR* 18, no. 15 (14 August 1920): 284-286; and his 'Letter to the Editor' trying to inform the African public and influence white employers about the disease, 'Prevention of Scurvy', *SAO* November 1924, 260-261.

<sup>638</sup> Shena Macvicar, *Notes on 208 Cases of Scurvy Treated in the Victoria Hospital*, Lovedale.

<sup>639</sup> *Ibid.*, 2-3.

<sup>640</sup> *Ibid.*, 23, 29. Unfortunately, the 18 month old, who was said to be very ill on admission, died. Both Strychnine and Digitalis were probably employed to stimulate the heart, as heart failure was the actual cause of death in most scurvy mortality cases. Digitalis is used as the name for the dried leaves of the plant 'foxglove'. Strychnine is a highly poisonous alkaloid from the seeds of the plant, *Strychnos nux-vomica* (a rather telling name!), which affects the central nervous system, and has been used as a poison, but was used, by some within Western circles, as a medical stimulant.

contribution from the medical missionary personnel of Victoria Hospital. The insight into the disease itself, its presence within and impact upon the wider health climate of the population of the Eastern Cape region, as well as conclusions on treatment and prevention not encountered in other literature up to that time are a clear example of the serious attitude to professional academic pursuits on the part of some Lovedale medical missionaries.<sup>641</sup>

## ***Tuberculosis***

### *Background*

While academic and professional pursuit of the understanding and impact of disease comprised part of the approach toward medical missionary work for some members of Lovedale, another aspect of Neil Macvicar's labour can be analysed through the medium of dealings with tuberculosis. Early in his time at Lovedale, Macvicar was involved not simply with the medical treatment of tuberculosis, but providing health education on the topic as well. One lecture on the subject was given at the Lovedale Literary Society,<sup>642</sup> which he later published for wider distribution. Indeed, aspirations for health classes for Lovedale's High School students were already on his mind in these early days.<sup>643</sup>

Of the many diseases, sicknesses, and medical complications encountered at Victoria Hospital, it was tuberculosis which grabbed Macvicar's attention at the

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<sup>641</sup> Ibid., 31-33. Further, her work provided a groundwork for wider discussion on the presence, impact, and preventative health work to be done to combat the deficiency diseases amongst the black African population. See also, N Macvicar, 'The Prevalence of Certain Diseases among the Natives of the Ciskei', *SAMJ*: 723.

<sup>642</sup> Or possibly the town of Alice Literary Society.

beginning stages of his medical missionary career at Lovedale. While Blackwater Fever was of particular importance during his period in Blantyre, Malawi, in the last years of the 19<sup>th</sup> century, it was this ‘Victorian disease’ which drew attention in South Africa. Tuberculosis, frequent and severe in its presence amongst patients at the Victoria, caused him to conduct study on the subject, culminating in papers printed in South African medical journals,<sup>644</sup> as well as other writings in *The Christian Express* and *The South African Outlook*,<sup>645</sup> and in work which earned him an M.D. from Edinburgh in 1907, *Tuberculosis Among the Natives of South Africa*.<sup>646</sup> It was this latter piece which propelled him to a high standing within the South African medical community on the subject of TB, a topic which continued to attract his attention through the decades, though not at all on the same level in his

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<sup>643</sup> Neil Macvicar, Lovedale, to D.A. Hunter, 17 September 1905, ‘A’, pp. 2-3, PR 4150 (folder ii), LC CL.

<sup>644</sup> Neil Macvicar, ‘The Relation of Altitude and Dryness of Atmosphere to the Spread of Consumption among the Native Races of South Africa’, *SAMR* 4, no. 9 (25 May 1906): 133-134; ‘Tuberculosis Amongst the Coloured Population of South Africa’, *SAMR* 8, no. 4 (26 February 1910): 39-45; ‘Tuberculosis of Bones and Joints in Native Patients in the Ciskei’, *SAMJ* 9, no. 18 (28 September 1935): 643-645.

<sup>645</sup> Neil Macvicar, ‘Tuberculosis Among the Coloured Population of South Africa’, *CE* September 1909, 144-148; ‘The Report of the Tuberculosis Commission’, *CE* November 1914, 164-165; ‘Tuberculosis in South Africa’, *SAO* October 1924, 232-233; ‘The Problem of Tuberculosis Among the Native Labourers in the Gold Mines’, *SAO* July 1926, 155-156; ‘Tuberculosis Among the South African Bantu. An Epoch-Making Report’, *SAO* October 1932, 195-197. While some of these do not accord authorship to Macvicar in the articles themselves, they are ascribed to him by R.H.W. Shepherd in his biography of Macvicar; see Shepherd, *A South African Medical Pioneer*, Appendix II, 232-243. There were other articles which I maintain Macvicar authored on this subject, which are addressed below.

<sup>646</sup> The thesis was then published in *The South African Medical Record* over a number of issues in 1908 (with a slightly altered title): ‘Tuberculosis among the South African Natives’, *SAMR* 6 (10 June 1908): 161-176; (25 June 1908): 181-185; (10 July 1908): 197-208; (25 July 1908): 213-222; (10 August 1908): 229-235. As well, the Lovedale Press published a copy: *Tuberculosis Among the South African Natives* (Lovedale: The Lovedale Press, 1908). His aim in the thesis was to compile a review of the then current distribution of the disease and factors associated with its history. Amongst other suppositions, he concluded that bovine tuberculosis was not to blame for much of the presence of TB, a conclusion that another leading South African authority explicitly cited and gave his assent to a few years thereafter. “I fully agree with Dr. Macvicar, who concludes that bovine tuberculosis has at present little to do with the production of human disease”. David P. Marais, ‘The Anti-Tuberculosis Movement in South Africa’, in *The Control and Eradication of Tuberculosis: A Series of*

latter years as in his earlier. Nevertheless, it arguably stands that Neil Macvicar gave more attention to tuberculosis – through scholarly, missionary, medical, and governmental advisory roles – than any other medical missionary of his day.<sup>647</sup> And it is through the medium of this disease that I look at elements of his role, thought, and general impact on matters of health in South Africa during his career.

Alternatively known by a number of names during this period – such as Consumption, Pthisis, Scrofula, White Plague, or TB – Pulmonary Tuberculosis was the particular bacteriological condition in which the tubercle bacilli infected the lungs of a sufferer. While the tuberculosis bacteria can infect any number of places within the body – such as bones, joints, glands, or the spine – it is the lungs which are especially susceptible to the disease. And if the disease progressed from a latent infection to active disease, the prognosis, while not necessarily fatal, was often dire during much of this period. The typical treatments centred on spending time in a sanatorium or moving to a warm dry climate,<sup>648</sup> a factor which saw a number of infected British citizens immigrate to South Africa.

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*International Studies by Many Authors*, ed. by Halliday G. Sutherland (Edinburgh: William Green & Sons, 1911), 247.

<sup>647</sup> Dr H.W. Dyke, the Principal Medical Officer for Basutoland at the time, specifically acknowledged Dr Macvicar's 'Anti-Tuberculosis propaganda' as a most notable record amongst a few other outstanding achievements in a brief tribute to him before his Presidential Address to the South African Health Society, H.W. Dyke, 'Health Conditions and Medical Services in Basutoland', *SAHSM* 80 August 1938, 1.

<sup>648</sup> L. Fred Ayvazian, 'History of Tuberculosis', in *Tuberculosis: A Comprehensive International Approach*, edited by Lee B. Reichman and Earl S. Hershfield (New York: Marcel Dekker, Inc., 1993), 4, 6. Ayvazian mentions other therapies, such as dietary regulations, horseback riding, hygiene regimens, as well as other treatments during the 18-19<sup>th</sup> centuries, such as bloodletting, starving, vomiting, and blistering, 4, 6. Williams expands on some of the dietary remedies or treatments which were employed, citing the use goat's milk, wine, gruel, cod liver oil, and general gorging, as well as bathing in various waters, such as sea or special springs; Harley Williams, *Requiem for a Great Killer: The Story of Tuberculosis* (London: Health Horizon Limited, 1973), 8, 35.



While from a period as early as Aristotle (who mentioned scrofula in swine) there had been isolated expressions of the belief that tuberculosis was a contagious disease, the predominant theory for centuries was that it was a hereditary disease, while others pointed to environmental or constitutional factors, and some favouring its contagiousness.<sup>649</sup> With the rise of more specialized medical techniques and medical discoveries during the 18<sup>th</sup> and 19<sup>th</sup> centuries, such as the invention of stethoscope or the use of microscopes, shafts of light began to be shed upon the truth of what the ailment actually was, as well as how it spread.<sup>650</sup> Yet it was the work of the German scientist, Robert Koch, who had broken new ground on the aetiology of infectious diseases in 1879, who discovered the tuberculosis bacillus (*Mycobacterium tuberculosis*) and revealed his findings in 1882. Koch's insights on the aetiology of the disease was not limited to the realm of tuberculosis and, in fact, fundamentally opened up the whole new field of bacteriology. His feats in 'discovery', however, did not extend to the realm of cure. In this, along with his contemporary scientific colleagues, biomedical treatment and cures for tuberculosis remained elusive to the whole field period prior to the discoveries in the 1940s which witnessed both anti-bacterial breakthroughs as well as other factors leading to better health.<sup>651</sup>

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<sup>649</sup> Porter, *The Greatest Benefit to Mankind*, 441.

<sup>650</sup> Ayvazian, 'History of Tuberculosis', in *Tuberculosis*, 2-5.

<sup>651</sup> Along with Koch's downfall regarding his 'secret cure' (a reference to the occasion in which he lied about having found a cure, but would not share the secret with anyone), amongst other disappointments, there certainly were advances, such as the Bacille-Calmette-Guérin immunization method, which was rather effective from as early as 1906. See, Porter, *The Greatest Benefit to Mankind*, 436-445.

The situation today, of course, has seen rather dramatic increases in the number of active disease cases in many Westernised countries, and indeed, according to the Centers for Disease Control and Prevention website, about one third of the world population is infected with TB, with 9 million

Pulmonary tuberculosis, though sometimes misdiagnosed or mislabelled, had been a great concern for both common folk and health authorities alike within much of Europe for centuries, and the 19<sup>th</sup> century was no different. Residents of cities and industrial centres tended to be especially hard hit. Yet by the second half of that century, with greater understandings of the disease taking place, mortality rates from TB were falling in much of Britain.<sup>652</sup> While this may have been the case in portions of the British Isles, the disease was gaining traction in the South African portion of the empire.

By the latter decades of the 1800s TB was becoming a severe enough problem in the Cape Colony that attention was even paid to its growing presence amongst the African “Natives”. In an anonymous letter to the *Cape Mercury* newspaper, a writer (who signed off as “Observer”) called not simply for enhanced governmental public health measures, but more intelligent and robust work that was better targeted toward the intended African audience. Rather than simply talking about the disease through the vehicle of the local church, as an article in *The Christian Express* had advocated, this anonymous author called for pamphlets, public health information, and laws all to be written in Bantu languages and widely distributed.<sup>653</sup> Nearly thirty years later, Macvicar and fellow workers were part of the South African public health *avant garde* doing these very things! Nevertheless,

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becoming sick every year with the disease, and almost 2 million deaths from the sickness every year. Online at: [http://www.cdc.gov/tb/WorldTBDAY/resources\\_global.htm](http://www.cdc.gov/tb/WorldTBDAY/resources_global.htm) (Site accessed 8 March 2008)

<sup>652</sup> Lane, *A Social History of Medicine*, 141-143.

<sup>653</sup> This brief account was wholly quoted in *The Christian Express*, as it did with many succinct articles from varying sources (both religious and secular press included) during this period. See, ‘Consumption Among Natives’, *CE* July 1878, 11.

the disease's early inroads and origins within the southern portion of the continent were not well understood.

#### *Macvicar's Contribution*

The epidemiological history of tuberculosis in South Africa was a topic which Macvicar was one of the first to take up in a scholarly manner; indeed, this was a central concern of his doctoral research work. Garnered through extensive feedback from varying (though nearly all white) medical authorities and other sources familiar with black African populations, portions of his literary output on the matter have, however, sometimes been misread or ignored. Randall Packard's historical work on the subject of tuberculosis in South Africa, *White Plague, Black Labor*, is certainly an insightful text on this matter. He has, at certain points, however, not done justice to Macvicar's renderings of the disease's introduction and early spread. Packard wrote that Macvicar maintained, "in his 1907 thesis on the early history of TB in South Africa, that TB had been introduced into South Africa by the Europeans".<sup>654</sup>

However, the specific citation Packard here used was one in which Macvicar was referring to the Bantu speaking races specifically, and a conclusion which he based specifically on the use and etymology of words within the Bantu languages for tuberculosis, something which he himself admitted he was not an authority on.<sup>655</sup> Just a page earlier, at the end of a section on 'the Bushmen', Macvicar wrote, "Is it

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<sup>654</sup> Randall M. Packard, *White Plague, Black Labor* (Pietermaritzburg: University of Natal Press, 1990), 22. Note Packard's mis-spelling of Macvicar: McVicar. I believe that other incorrect spellings, as in Zondi's work, can probably be traced back to this.

<sup>655</sup> Neil Macvicar, 'Tuberculosis among the South African Natives', *SAMR* 6, no. 13 (10 July 1908): 204.

not possible that tuberculosis may have been present, may even have been common, among the Bushmen in their primitive state? ....but, in view of the wide spread of tuberculosis throughout the world, it seems somewhat rash to conclude, in the total absence of proof, that it did not exist among any given people.”<sup>656</sup> He went on, “At present I can only suggest that the presence of tuberculosis among the Coloured and Bushmen races of the present day may possibly be explainable on the quite simple hypothesis that they have had the disease among them from the earliest times.”<sup>657</sup>

This is not to say, however, that Macvicar did not think that Europeans were largely responsible for the more contemporary influx of the disease. He clearly did. “Whatever may be the share that the other races have had in originating tuberculosis in South Africa, the European race has certainly been responsible during recent years for its introduction in the wholesale manner.”<sup>658</sup> From a relatively early point in his time in South Africa Macvicar believed that the Europeans brought with them tuberculosis. “Civilization has brought with it tuberculosis, but the civilized races who have brought it know it as an old enemy and have learned how to combat it. To the natives it is a new enemy, and all the civilization they have so far learned has not taught them how to deal with tuberculosis.”<sup>659</sup> Indeed, he saw tuberculosis as a disease attached to elements of the civilising effects which the whites were bringing

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<sup>656</sup> Ibid., 203.

<sup>657</sup> Ibid.

<sup>658</sup> Ibid., 205. Note also Macvicar’s thoughts on the possible introduction of the disease amongst the Zulu: “It seems not impossible that infection may have reached the Zulus either from the Indians or the Portuguese further up the coast... it may be that the Indians are infecting the Natives. As regards East Central Africa, the evidence seems to point to the Zanzibar Arabs as the chief introducers of tuberculosis”. Ibid., 205-206.

<sup>659</sup> ‘Report of the Medical Officer of Health for the Colony’, *CE* September 1905, 130. His statement in this regard, while perhaps true regarding the origin of its appearance in southern Africa, was far too

with them. In this sense, it was a negative side-effect of the otherwise positive and progressive, even Christian, endeavour of civilisation. He therefore engaged with the white population – medical authorities, government, general population, etc. – in addition to the African populace – patients, general public, educated elite, etc.

Though not explicitly attributed to Macvicar, the title of the lead article in the February 1905 edition of *The Christian Express* conveyed a stark message regarding the role of Tuberculosis in southern Africa: ‘The Future Scourge of the Native Races.’<sup>660</sup> The title was taken from a statement made by the Medical Health Officer of the Cape Colony and was an indication of the reality of tuberculosis’ presence within the South African setting. By the early years of the 20<sup>th</sup> century, the disease was undoubtedly spreading amongst the black African population in the Cape, most especially in the urban areas. This was seen to be all the more alarming when juxtaposed with the figures of steady decline in England and Wales over the previous few decades, and corresponding falling TB mortality figures amongst whites in the Cape. The growing number of cases amongst black Africans was attributed to a number of factors such as increased travel among the population (and thus a higher and more diverse exposure rate), overcrowded living conditions, unhygienic

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complimentary given the West’s history with the disease and the only recent conclusive discovery of its bacteriological nature. On the authorship of this piece, see notes below.

<sup>660</sup> As mentioned, while this article is not explicitly ascribed to Macvicar, I believe that he was indeed the author. The subject matter and authority with which the author speaks on the subject do not allow for any other notable options within the Lovedale community, and an outside author would almost certainly have had his or her name or initials at the end. See, ‘The Future Scourge of the Native Races’, *CE* February 1905, 17-18. Furthermore, I believe the same is true for another lead article which dealt with the subject of tuberculosis, ‘Report of the Medical Officer of Health for the Colony’, *CE* September 1905, 129-130. Such lead editorials were often written by those within the Lovedale community, depending upon the subject, of course, and subject to the editor’s choice. And as Macvicar made note of authoring lead editorials on education in personal letters to D.A. Hunter very early in his time at Lovedale, it is likely that this process continued.

manners, unsanitary housing, and insufficient diets which led to weakened physical states and higher susceptibility.<sup>661</sup>

By his standards, the dissemination of the disease could only be arrested in a multi-pronged attack, led by a number of groups and through a host of Western tactics. The government itself was believed to be the party most responsible for taking action against the spread of the disease, primarily through its ability to proclaim it an infectious disease (which had been done in March of 1903) and then call for doctors and the public to act accordingly.<sup>662</sup> The varying levels of government, however, were not the only major players in trying to disseminate information about the disease and efforts to eradicate its spread. Missionaries were seen as primary communicators, especially within the rural context, while another centred on teaching the subject of health to teachers and having schools give lessons on hygiene as well as elements to include in house building (windows and doors were seen as especially profitable – both for the allowance of sunlight as well as fresh air).<sup>663</sup>

In a paper read to the 1909 South African Medical Congress in Durban, Macvicar rather explicitly mentioned that the low incidence of TB among non-immigrant white communities within the country was the primary reason for white

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<sup>661</sup> Neil Macvicar, 'The Relation of Altitude and Dryness of Atmosphere to the Spread of Consumption among the Native Races of South Africa', *SAMR* 4, no. 9 (25 May 1906): 133; 'The Future Scourge of the Native Races', *CE* February 1905, 17; see also, Section V in his thesis: 'Factors which influence the spread of tuberculosis among the Natives' in, 'Tuberculosis among the South African Natives', *SAMR* 6, no. 13 (10 July 1908): 206-208, and *SAMR* 6, no. 14 (25 July 1908): 213-222.

Such explanations and evaluation of non-Western societal standards regarding TB, seen as inferior if not altogether ignorant, was common in missionary discourse on the subject. See, for example, Kilborn, *Heal the Sick*, 76.

<sup>662</sup> 'The Future Scourge of the Native Races', *CE* February 1905, 17.

apathy on the issue of confronting the public health dilemma. Quite simply, it was seen as a 'black' and 'coloured' problem. Without sounding alarmist, he reminded the audience that black servants and workers could easily transmit the disease to the middle and upper class whites.<sup>664</sup> Furthermore, he noted that the white lower class was more susceptible to the disease for economic and social reasons, and that it therefore had the potential to grow in this 'poor' portion of the white population as well.<sup>665</sup> It seems that although certain sectors of the white populace may have been ignoring the health climate amongst the black population, Macvicar was trying to make the point that tuberculosis, while not an imminent threat to the upper white classes, could not be segregated along racial lines. It was a wake up call for awareness as well as action. Without trying to overemphasize the language used, one clearly senses the missionary zeal in his effort to urge the overwhelmingly white medical congress to act to disseminate Western understandings of the nature and cause of TB. Indeed, one could almost substitute 'sin' for 'tuberculosis' or 'disease' with it sounding like the Christianizing of a nation:

I think the main effort of our profession and of everyone working for the reduction of tuberculosis should be to rouse the people concerned, i.e., the natives themselves, to a sense of the gravity of the situation, and to the need for effort on their own part. Let us give them all the information we can. Without information, no one will make an effort. Let us tell them for their encouragement that in other countries that were once heavily afflicted by tuberculosis, the disease is now year by year being steadily reduced. Let us educate them by means of every agency we possess, by means of dispensaries, hospitals, schools, health societies, and literature.<sup>666</sup>

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<sup>663</sup> Ibid., 18.

<sup>664</sup> It had earlier been pointed out that an estimated 9 out of 10 white children were brought up by black 'nurse-maids'. Ibid., 17.

<sup>665</sup> Neil Macvicar, 'Tuberculosis Amongst the Coloured Population of South Africa', *SAMR* 8, no. 4 (26 February 1910): 39.

<sup>666</sup> Ibid., 44-45.

In this way, the drive to educate and bring their 'special knowledge' of how TB spread brings forth the nature of Macvicar's missionary background within the medical discourse; medical knowledge was not seen as the property of the trained elite community of medical professionals, but something to be wholly transmitted to the masses, in order that it would bring benefit to the wider arena of public health.<sup>667</sup>



"TB joint cases in front of Vic. Hosp. in 1930". Children receiving treatment outside in the sunshine. Fresh air and sunshine were seen as vital treatment methods for patients with tuberculosis by Macvicar and the Victoria Hospital staff.<sup>668</sup>

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<sup>667</sup> Due to space constraints, this section does not allow for greater detail and analysis of Macvicar's paper presented at the Durban conference mentioned in the notes above. For more on his recommendations, calls for governmental policy changes, and interaction with the international tuberculosis commissions, see 'Tuberculosis Amongst the Coloured Population of South Africa' *SAMR* 8, no 4 (26 February 1910): 39-45. For modern work on the subject of health policies within a specific region of South Africa, see: Randall M. Packard, 'Tuberculosis and the Development of Industrial Health Policies on the Witwatersrand, 1902-1932', *JSAS* 13, no. 2 (January 1987): 187-209.



When the Report of the Tuberculosis Commission was released in 1914, Macvicar's response was in favour of its recommendations, such as the call for government statistics to be kept not simply for whites but everyone, as well as its open acknowledgment regarding the wretched conditions for blacks working at the mines. However, he did not withhold criticism, remarking that the report itself, "show[s] signs of bias and unfairness."<sup>669</sup> It is quite striking to note some of the recommendations that the Commission made, seeing as how they echoed Macvicar's earlier calls for improved housing; increased health education in schools, as well as in teaching teachers and using open-air classes; TB dispensaries, hospitals, and sanatoria; and the appointment of Health Officers.<sup>670</sup> It is quite reasonable to see more than a little of Macvicar's influence on these recommendations. These elements are not incidental and, in fact, stand as a direct contradiction to Packard's contention about European missionaries who had, "blissfully ignored the economic realities that underlay the Africans' lack of proper housing and diet."<sup>671</sup>

In addition to his advocacy to sectors of the white population, 'educated natives' and the 'Native Press' were believed by him to be the ones who could do the most for their fellow 'unenlightened' black Africans. It was through educated black 'Sanitary Inspectors' and 'Health Instructors' that Macvicar believed a great deal of information and example would then be spread throughout the outlying regions. Echoing his reasoning in educating black nurses, Macvicar was convinced it would

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<sup>668</sup> AMKWT 1677/SH 032/H/B

<sup>669</sup> Macvicar, 'The Report of the Tuberculosis Commission', *CE* November 1914, 164.

<sup>670</sup> Look specifically at Macvicar's Section 7 in his thesis, 'Possible Methods of Dealing with the Problem', in 'Tuberculosis Among the South African Natives', *SAMR* 6, no. 15 (10 August 1908): 230-233, particularly 231-232.

<sup>671</sup> Packard, *White Plague, Black Labor*, 51.

not only prove fruitful for the individuals themselves, but that such people were the only ones who could effectively communicate such ‘scientific truths’ to the African masses.<sup>672</sup>

In his discourse on the ‘enlightened’ or ‘civilised’ manners of treating and attempting to arrest the incidence rate of TB, it is important to note a couple of aspects of Macvicar’s belief regarding this. While the vast majority of the discussion on TB was not at all vulgar, Macvicar did not shy away from rather crude images in his depiction of ‘Native’ manners, writing of the sick expectorating sputum on the hut floor and the consequent spread of disease. Indeed, the ‘Native hut’ was seen by him as a nearly perfect incubator for the dissemination of the sickness:

It is difficult to imagine a more suitable contrivance for the storing up and conveyance of phthisical infection than a native hut. Sunlight is the great enemy of tuberculosis, and a native hut is just a patch of the earth’s surface from which sunlight is most carefully excluded. Dust is probably the commonest medium by which the infection of phthisis is conveyed to the lungs, and the earthen floor of the native hut is of all floors the one most liable to produce dust and the most difficult to disinfect. In short it cannot be too plainly stated that if the natives are to save their race from the peril of tuberculosis *they must radically reform their houses and their mode of life.*<sup>673</sup>

The irony is that he lamented the fact that the traditional practice of burning down a hut after a death in the hut was all but abandoned amongst the more Westernised Africans, “In former days it was a custom among the natives to burn down a hut in which a person had died. That custom, especially among civilised natives, has fallen largely into disuse, though, following upon cases of death from phthisis, it would be of the greatest value.”<sup>674</sup> This minor interplay between Western methods or standards and traditional South African dealings with TB reflects the larger issues at

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<sup>672</sup> ‘Report of the Medical Officer of Health for the Colony’, *CE* September 1905, 130.

<sup>673</sup> *Ibid.*, [emphasis his].

<sup>674</sup> ‘The Future Scourge of the Native Races’, *CE* February 1905, 17.

play in the collision of ways of life and understandings of the world that were of pre-eminent importance during this period of mission and medical history. That is, in this case, at least, Macvicar was not afraid to admit to aspects of traditional culture which proved an aid to better health, while acknowledging elements of problematic Western cultural intrusion.

## ***Influenza***

As touched upon previously in this chapter, epidemics were an important field in the ‘battle with disease’ for many medical personnel in the missionary setting. However, no other epidemic had as great an impact, in the worldwide setting, as the 1918-1919 Influenza Pandemic, often referred to as ‘the Spanish Flu’. Due to its severity, notoriety, and length, the interaction with this disease was looked upon more as an ‘event’, rather than an ongoing danger. With that said, however, influenza itself occurred seasonally, and was a common illness for which some people sought treatment at the hospital.<sup>675</sup> In this portion of the chapter, I examine the disease’s ongoing presence, then analyse the impact and response of the 1918 outbreak in the medical work of the Victoria Hospital.

### *Seasonal Impact of Influenza at Lovedale*

Influenza viruses have often been incorrectly identified as the ‘common cold’, due to their shared symptoms. In its variant forms and mutations, however,

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<sup>675</sup> See, for example, reports from Blantyre, Malawi, in the local missionary periodical: “Influenza has been making its presence felt amongst us. Several of the members of the staff have been laid up with it.” “This bitter month of June has brought with it our old familiar enemy the Influenza, and our white staff has been laid low. It has been said that the Influenza epidemics of recent years have seriously lowered the mental tone of Europe. We can well believe it.” *LWBCA* 136 (June 1899): 1, 2.

influenza viruses have been, and continue to be, a regular cause of hospitalisation and even death.<sup>676</sup> In an early report submitted to *The Journal of Tropical Medicine*, Macvicar provided a breakdown of his diagnoses for over 2,700 “Bantu Out-Patients” from his first fourteen months of work at the Victoria Hospital, October 1902 through December 1903.<sup>677</sup> While providing an extremely interesting amount of data, as well as his perceptions of varying illnesses, injuries, and diagnoses – such as 9 incidences of “hypochondria”, 2 cases of “feigned sickness”, 5 determinations of “lunacy”, one occurrence each of “Housemaid’s knee” and skin “eruption after eating pork”, as well as bites from men and dogs, and injuries incurred from *sjamboks* – this article also reveals that Influenza was the highest reported complaint amongst out-patients during the period. While there was a high incidence of varying forms of tuberculosis (191)<sup>678</sup>, as well as whooping cough (181), enteritis (127), dysentery (124), and bronchitis (157), influenza registered 225 cases. As such, roughly one in every twelve out-patients was seen for complaints that Macvicar diagnosed as ‘Influenza’.

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<sup>676</sup> The Centers for Disease Control and Prevention, in the United States, maintains that influenza complications cause approximately 200,000 hospitalisations and 36,000 deaths in that country every year. Online at: [www.cdc.gov/flu/about/disease/index.htm](http://www.cdc.gov/flu/about/disease/index.htm)

Notice the comments surrounding the presence, impact, and understandings of influenza at the Blantyre mission in 1899: “Influenza has been making its presence felt amongst us. Several of the members of the staff have been laid up with it. The recent trying weather with its extremes of heat and cold, must be held responsible for much of it. People at home can hardly realise the very depressing effect that cold produces on residents in the tropics.” And further, “This bitter month of June has brought with it our old familiar enemy the Influenza, and our white staff has been laid low. It has been said that the Influenza epidemics of recent years have seriously lowered the mental tone of Europe. We can well believe it.” *LWBCA* 136 (June 1899): 1, 2.

<sup>677</sup> All of the information within the paragraph was ascertained from this account, unless otherwise noted: Neil Macvicar, ‘Analysis of 2,739 Bantu Out-Patients’, *JTM* VIII 15 June 1904, 181-182.

<sup>678</sup> Macvicar noted that he was quite sure that, “the majority of the cases of pleurisy [56] and some of those of pneumonia [Lobar, in adults, 18; and 39 cases in children] and bronchitis [124 acute, 33 chronic] were without doubt tubercular; also a few out of the other categories. Considerably over 200, therefore, of our out-patients were suffering from tuberculosis”.

The 'flu was indeed an ordinary medical complaint and therefore qualified for an entry in Macvicar's *English-Kafir Nurse's Dictionary*.<sup>679</sup> Because it was so common, influenza rarely garnered much special attention, especially amidst other diseases which seemed to need more pressing consideration. It was therefore seldom mentioned in reports or general health write-ups provided by the hospital, especially prior to the great pandemic. With that said, however, "influenza and bronchitis" accounted for twelve admissions into the hospital, among a total of 496 in-patient check-ins, in 1914<sup>680</sup>, and influenza alone tallied thirty-four in-patient admissions in 1915<sup>681</sup>, fifty-one in 1916, and twenty-nine cases in 1917.<sup>682</sup> Unfortunately, however, Macvicar never provided any documentation related to the typical treatment given to in-patients, or health advice and/or medicines provided for out-patients. Such information, and other related aspects of medical mission care for those ill with influenza at Lovedale, only come out in the records related to one of the most calamitous 'events' of the 20<sup>th</sup> century, the 1918-19 Influenza Pandemic.

#### *Background of the 1918-1919 Influenza Pandemic*

On the 7<sup>th</sup> of September, 1918, an American soldier based at Camp Devens, in the Northeastern state of Massachusetts, came down with what was incorrectly diagnosed as cerebral meningitis. In a matter of just 11 days, nearly 1,200 of his fellow recruits were admitted to the hospital, and over 6,500 cases had been reported

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<sup>679</sup> Neil Macvicar, *English-Kafir Nurse's Dictionary*, (n.p. [Lovedale]: Lovedale Mission Press, n.d. [c. 1907]), 41. His 'Influenza' entry in the Second Edition, published a few decades later, was largely unchanged, though minor spelling and grammatical alterations were made. See, Neil Macvicar, *English-Xhosa Dictionary for Nurses*, (n.p. [Lovedale]: Lovedale Press, n.d. [1935]), 47.

<sup>680</sup> Macvicar, 'Victoria Hospital, Lovedale: Report of the Medical Superintendent for the Year 1914', *CE* February 1915, 32. It did not account for any of the 20 deaths that year in the hospital.

<sup>681</sup> Macvicar, 'Victoria Hospital, Lovedale – Report for 1915', *CE* February 1916, 30.

at the 45,000 person army camp.<sup>683</sup> The sickness, however, was not cerebral meningitis. It was influenza, and shortly thereafter it became more popularly known as the ‘Spanish Flu’,<sup>684</sup> especially during this most lethal wave of the Pandemic. But whatever it was called – flu, la grippe, the ‘Spanish Influenza’, the ‘Spanish Lady’, grip, ‘Chungking fever’, ‘wrestler’s fever’<sup>685</sup> – or misdiagnosed as, the fact remains that it killed more people throughout the world than any other natural disaster of the twentieth century, and probably more than the plague of the mid-fourteenth century.

While almost every writer on the subject agrees that the death total was over 20 million, the question of just exactly how many it killed remains a mystery. One of the earliest pieces of literature on this subject, by Edwin Oakes Jordan, tallied the total at 21.6 million.<sup>686</sup> Some modern writers have stuck to this lower estimate of roughly 20 million,<sup>687</sup> while Howard Phillips and David Killingray, in a recent book on the subject, have put the mortality figure at about 30 million worldwide, though they humbly acknowledge that it is, ““no more than an informed estimate””.<sup>688</sup> John Oxford, the noted virologist, called it: “the largest outbreak of infectious disease that

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<sup>682</sup> Macvicar, ‘The Victoria Hospital, Lovedale. Report for 1917’, *CE* February 1918, 25.

<sup>683</sup> Alfred W. Crosby, *America’s Forgotten Pandemic* 2<sup>nd</sup> Edition (Cambridge: Cambridge University Press, 1999), 4-5.

<sup>684</sup> It seems likely that the terminology, ‘Spanish Flu,’ had been adopted due to the fact that when the virus struck the inhabitants of Spain in its first of three ‘waves,’ the reporters of this neutral country were not being censored (unlike most of the other reporters in war-torn Western Europe at the time), so their stories about the sickness ‘got out’ to the wider public. Gina Kolata, *Flu: The Story of the Great Influenza Pandemic of 1918 and the Search for the Virus That Caused It* (New York: Farrar, Straus and Giroux, 1999), 10.

<sup>685</sup> A.A. Hoehling, *The Great Epidemic* (Boston: Little, Brown and Company, 1961), 5, 20-21.

<sup>686</sup> Edwin Oakes Jordan, *Epidemic Influenza* (Chicago: American Medical Association, 1927).

<sup>687</sup> Youri Ghendon, ‘Introduction to Pandemic Influenza through History’, *European Journal of Epidemiology* 10, no. 4 (August 1994): 451. Note, however, that just a page later Ghendon conjectures the much more indistinct estimate of 20-40 million.

<sup>688</sup> Howard Phillips and David Killingray, “Introduction,” in *The Spanish Influenza Pandemic of 1918-19: New Perspectives*, ed. Howard Phillips and David Killingray (London: Routledge, 2003), 4.

the world has ever known”, putting the death toll at a range of *at least* 30 million.<sup>689</sup> Jeffrey Taubenberger, the molecular pathologist who led a team in the 1990’s that isolated the 1918 viral gene through preserved tissue samples from the time, estimates that there were, “up to 40 million dead.”<sup>690</sup> Even more recent than these estimates is an opinion which has figured, “Global mortality from the influenza pandemic appears to have been of the order of 50 million. However, even this vast figure may be substantially lower than the real toll, perhaps as much as 100 percent understated.”<sup>691</sup> Such a liberal estimate was actually first perpetuated by the Nobel laureate Macfarlane Burnet, who spent a great deal of time studying influenza. His opinion was that the worldwide death toll ought to be in the range of 50 to 100 million lives.<sup>692</sup> While the exact number of people who died from this affliction will never be known, just as our ignorance will surely remain as to its exact beginnings,<sup>693</sup> it is more than clear that this contagion was one of the most far reaching and detrimental disease killers in the history of the modern age while

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<sup>689</sup> John S. Oxford, “A Virologist’s Foreword,” in *The Spanish Influenza Pandemic of 1918-19*, xvii. [emphasis mine]

<sup>690</sup> Jeffery K. Taubenberger, “Genetic characterization of the 1918 ‘Spanish’ Influenza virus,” in *The Spanish Influenza Pandemic of 1918-19*, 39.

<sup>691</sup> Niall P.A.S. Johnson and Juergen Mueller, ‘Updating the Accounts: Global Mortality of the 1918-1920 “Spanish” Influenza Pandemic’, *Bulletin of the History of Medicine* 76 (2002): 115.

<sup>692</sup> John M. Barry, *The Great Influenza* (New York: Viking Penguin, 2004), 397.

<sup>693</sup> J.S. Oxford has examined varying evidences leading him to believe that the pandemic may have originated in Europe and ‘incubated’ there, so to speak, prior to the worldwide outbreak. See, J.S. Oxford, ‘The So-Called Great Spanish Influenza Pandemic of 1918 May Have Originated in France in 1916’, *Philosophical Transactions of the Royal Society, London* 356 (29 December 2001): 1857-1859; John S. Oxford, ‘A Virologist’s Foreword’, in *The Spanish Influenza Pandemic of 1918-1919: New Perspectives*, xviii-xix. Christopher Langford has made a substantial contribution with his contention that the pandemic may well have had its origins in China. See, Christopher Langford, ‘Did the 1918-19 Influenza Pandemic Originate in China?’, *Population and Development Review* 31, 4 (September 2005): 494. And Philips and Killingray briefly point to North American roots, ‘Introduction’, in *The Spanish Influenza Pandemic of 1918-19*, 5.

concurrently demonstrating the increasingly globalised world of the early 20<sup>th</sup> century.

The first wave, while certainly widespread, affected the northern hemisphere during the spring of 1918, but was not on par with more fatal strains. The more lethal second wave travelled around the world in approximately six months, undoubtedly becoming a pandemic, by the last weeks of 1918. It seems that this second wave of influenza, which had probably genetically mutated or ‘recombined,’ became deadlier with a closer tie to bacterial pneumonia in France sometime in the late summer (August).<sup>694</sup> From this area in France there were three major ports that helped spread the virus throughout the globe: Brest, France; Boston, United States; and Freetown, Sierra Leone.<sup>695</sup> With each of these very active seaports becoming harbingers of the disease, the sickness spread through various agencies of travel – across land as well as other means of marine commerce and traffic.

In Africa, as in many other parts of the world, the port cities were the first to succumb to the new suffering. After coming ashore with sailors in Sierra Leone, West Africa, the influenza travelled east along the coast, making landfall through various boats and ships that called on ports. Cape Coast, Ghana, reported it on the 31<sup>st</sup> of August and the virus turned up in the capital city of Accra just four days later. From Accra and other port cities, the sickness was slowly, but surely, spreading inland along travel routes.<sup>696</sup> On the 14<sup>th</sup> of September, the *SS Bida*, which had been

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<sup>694</sup> The tie to bacterial pneumonia was a feature repeatedly noted within the South African medical journals of the day.

<sup>695</sup> K. David Patterson and Gerald F. Pyle, ‘The Geography and Mortality of the 1918 Influenza Pandemic’, *Bulletin of History of Medicine* 65 (1991):8.

<sup>696</sup> K. David Patterson, ‘The Influenza Epidemic of 1918-19 in the Gold Coast’, *Journal of African History* 24 (1983): 486-487.



in Accra, called on Lagos, Nigeria, with sick passengers. By the 23<sup>rd</sup> there were cases reported in Lagos. From the large city of Lagos the flu spread north along the railway line, as well as eastward along the coast. By the end of the month and the first days of October, isolated cases were being reported in the eastern river city of Calabar.<sup>697</sup> And in the same way, the infection then spread inland on various travel routes – rivers, roads, railways – eventually covering the whole region.<sup>698</sup> As panic about the ailment spread, so did carriers, producing a morbid snowball effect. According to Ohadike, “In Port Harcourt nearly 1000 laborers deserted their jobs and returned to their home towns and villages, thereby introducing influenza into the outlying settlements”;<sup>699</sup> this was a scenario which was replicated in various locations, including the mines of South Africa.

The pattern described here in West Africa was typical for the rest of the continent as the spreading infection seemingly covered the entire continent by January or February of 1919 at the very latest.<sup>700</sup> Major railways carried the virus further inland in Kenya Colony and German East Africa from Mombasa. The same held true in South Africa as the disease landed at Cape Town and Durban. It then spread further north along the roads and railway system through Southern Rhodesia into Northern Rhodesia and then along the Congo River waterway in the Belgian

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<sup>697</sup> Don C. Ohadike, ‘Diffusion and Physiological Responses to the Influenza Pandemic of 1918-19 in Nigeria’, *Social Science & Medicine* 32, no. 12: 1394.

<sup>698</sup> In 1913 railroad systems in the South and North of Nigeria were merged, providing an even more expedient manner of this disease transmission to the northern portion of the country. See *Records of the Colonial Office, Dominions Office, Commonwealth Relations Office and Commonwealth Office*, vol. 1, London: Her Majesty’s Stationary Office, 1995.

<sup>699</sup> Ohadike, ‘Diffusion and Physiological Responses’, 1396.

<sup>700</sup> In a small article by a missionary from the area of Nyasaland, the author wrote that the Influenza hit the town of Zomba in early 1919, probably referring to January or February, a month or two later

Congo. From this area, as well as Douala, Kamerun, the flu branched north into Equatorial Africa and beyond.<sup>701</sup> As Patterson and Pyle starkly point out, “The nature of the 1918-1919 disease agent was such that influenza seemed to rage through sub-Saharan Africa as though the colonial transportation network had been planned in preparation for the pandemic.”<sup>702</sup> When combined with contemporary factors such as smallpox outbreaks and major famines in portions of the continent,<sup>703</sup> as well as inadequate understandings of what the illness actually was<sup>704</sup> – let alone how one ought to medically treat the sickness and/or care for the patient<sup>705</sup> – it is sadly little wonder that more than 2 million Africans died in the ‘Spanish’ flu pandemic.<sup>706</sup>

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than what would have been expected. Miss Christie, “Zomba,” *News of Women’s Missions: Foreign and Jewish*, May 1920, New Series no. 269, 18.

<sup>701</sup> K. David Patterson and Gerald F. Pyle, ‘The Diffusion of Influenza in Sub-Saharan Africa During the 1918-1919 Pandemic’, *Social Science & Medicine* 17, 17 (1983): 1303-1304.

<sup>702</sup> *Ibid.*, 1302.

<sup>703</sup> B.E.C. Hopwood, “Primary Health care in Uganda 1894-1962,” in *Health in Tropical Africa during the Colonial Period*, 148.

<sup>704</sup> See Barry, *The Great Influenza*, 231-241, for a sample of the varying medical misdiagnoses and some truly harrowing stories of complications with this influenza strain. From a more scientific point of view, a greater understanding of influenza really only came in 1933 as the micro-organism responsible for its viability was discovered, Phillips and Killingray, *The Spanish Influenza*, 6.

<sup>705</sup> Compare Patterson’s realistic pessimism, “Still, even if more doctors had been available, there was little they could have done,” (Patterson, 493) with W.P. Livingstone’s more heroic portrayal of Dr. John Hitchcock, a missionary doctor of the Calabar mission in Nigeria: “He fought the scourge night and day, ministering to Europeans and natives alike. One of his hardest battles was in the mission station at Ahofia, forty miles from Itu, where the Rev. R. Collins was laid low. *Dr. Hitchcock pulled him through*, and returned to Itu...” [emphasis mine], ‘The Beloved Physician,’ *The Record of the Home and Foreign Mission Work of the United Free Church of Scotland*, March 1919, 45. Livingstone’s work is very typical of hagiographic portrayals popular in much of the churches’ literary discourse.

<sup>706</sup> In Patterson and Pyle, “The Diffusion of Influenza in Sub-Saharan Africa During the 1918-1919 Pandemic,” 1299, they estimate at least 1.5-2 million. In Patterson and Pyle, “The Geography and Mortality of the 1918 Influenza Pandemic,” 14, they put the estimated total for all of Africa at 1.9-2.3 million, with Sub-Saharan Africa comprising the bulk, 1.7-2 million. Johnson and Mueller have given the figure of approximately 2.175 million for Sub-Saharan Africa (200,000 more for all of Africa if North Africa is added in), ‘Updating the Accounts: Global Mortality of the 1918-1920 “Spanish” Influenza Pandemic’, 110.

## ***The Influenza Epidemic and Lovedale***

In his book marking the centenary of Lovedale, Robert Shepherd has drawn brief attention to the presence of the Influenza Pandemic at the mission station, but the report is understandably cursory.<sup>707</sup> Herein I provide a much more comprehensive account and analysis of the crisis. To this end, the story of the epidemic and response at Lovedale is best analysed when broken into two inter-related categories: Lovedale and the communities outside Lovedale. Amidst all of these areas Dr Macvicar, as the chief medical authority, played a vital role. However, the work and leadership carried out in these responses, often medically, was anything but a solitary venture, involving varied members of the community.

### *Lovedale*

#### *The Victoria Hospital*

The first patient with influenza was admitted as an out-patient to the hospital on the 26<sup>th</sup> of September, 1918; with admissions continuing until the end of November.<sup>708</sup> As with so many other medical practitioners in South Africa,<sup>709</sup> most

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<sup>707</sup> Shepherd, *Lovedale South Africa 1841-1941*, 329-333.

<sup>708</sup> Macvicar, 'The Victoria Hospital, Lovedale, Report for 1918', *CE* February 1919, 27.

<sup>709</sup> Though more than simply addressing the high rate of morbidity and infection amongst medical personnel, in its last issue of the year, the *South African Medical Record* wrote in its lead article, "we cannot but be struck with the heavy toll in life which the disease has taken from our ranks. Up to now, we know of 35 deaths of medical practitioners..." This total, attained in just a few months, was far greater than typical *annual* death rates among this profession in the years preceding. One cannot help but wonder how much greater the number of infected doctors and nurses within South Africa was

of the nursing staff of the hospital (5 of 7) came down with the illness themselves during these few months. As a result, only the worst cases were admitted and students from the Lovedale campus were recruited to help the short-handed staff with a patient load which nevertheless totalled 68 cases during these last few months of the year.<sup>710</sup> Macvicar commented that the mortality rate of some of these patients with influenza, or secondary illnesses such as pneumonia, came to the hospital at such a point as to be beyond the hospital's ability to help. Such deaths were the primary reason for the spike in the annual number of deaths in the hospital for the year, from 25 in 1917 to 42 in 1918 (a 68% increase), though there were also 155 more in-patients admitted.<sup>711</sup> Unfortunately, Macvicar never recorded for posterity any medical treatments specifically employed at the hospital during this epidemic. He did, however, provide insight into the provisions made in the treatment at other extemporaneous medical locales set up within Lovedale and beyond.

#### *The Lovedale Institution*

While the first patient admitted to the Victoria Hospital came at the end of September, the temporary hospital for Lovedale boys was begun by the 11<sup>th</sup> of October.<sup>712</sup> In personal notes made by Macvicar on this period of his work (which I draw on extensively for this section), he recounted the first contact he had with the

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during this period? 'The Incidence of the Influenza Epidemic on the Profession', *SAMR* 16, no. 24 (28 December 1918): 373-374.

<sup>710</sup> Macvicar, 'The Victoria Hospital, Lovedale, Report for 1918', *CE* February 1919, 27. The total number of in-patient admissions for influenza for the year totalled 112. This compared to an average intake of 31.5 cases of admission for influenza in the four years previous to 1918, as evidenced in the Victoria Hospital Reports. See: *CE* February 1915, 32; February 1916, 30; February 1918, 25 (this contained information for both 1917 and 1916).

<sup>711</sup> Macvicar, 'The Victoria Hospital, Lovedale, Report for 1918', *CE* February 1919, 26-27; 'The Victoria Hospital, Lovedale, Report for 1917', *CE* February 1918, 25.

<sup>712</sup> Macvicar, 'The Victoria Hospital, Lovedale, Report for 1918', *CE* February 1919, 27.

outbreak at the Institution, demonstrating the pathogen's extraordinary speed and rate of transmission within such a setting:

My first contact with the epidemic was when I went down to the outpatient room one morning. (At that time I saw sick boys at 7 a.m.) I found about twenty boys, most of whom were lying flat on the floor. The floor was covered with them. I was told others were ill in the dormitories. After attending to these boys and having breakfast I went to the dormitories and went systematically through them. Before me went an orderly taking temperatures and with me came another, writing down treatment prescribed. There was not a dormitory that had not boys ill in bed.... I was the greater part of the forenoon getting round. The same thing happened in the afternoon though then I got quicker round as I had notes of the cases.<sup>713</sup>

Shortly thereafter, Mr F. Preston, the woodwork instructor in the Industrial Department of the Institution, proposed that his workshop-classroom become a makeshift nursing ward for the sick young men. The Rev. Dr. James Henderson,<sup>714</sup> Principal of the Lovedale Institution, had been attending a meeting in East London<sup>715</sup> at the time of the outbreak's occurrence at Lovedale, and upon his return and approval the suggestion was taken up.

With four rows of mattresses on the floor filled with approximately 70 of the worst cases at the Institution,<sup>716</sup> the nursing began. Overseeing the operation were Dr. Henderson and Dr. Alexander Roberts,<sup>717</sup> the long serving Principal Teacher of the Training School, and two-time Acting Principal of Lovedale. Between the two of

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<sup>713</sup> Macvicar, 'Notes on Influenza Epidemic', MS 14,754 LC CL, [1].

<sup>714</sup> Henderson had actually taken some of the medical course classes in Edinburgh in the early 1890s, during the same period as Macvicar. However, he never completed them or qualified in medicine, as he departed for Malawi under the Free Church of Scotland mission at Livingstonia before this could happen. R.H.W. Shepherd, *Lovedale South Africa 1824-1955* ([Lovedale]: The Lovedale Press, 1971), 70.

<sup>715</sup> Henderson had been at an Association of the Heads of Native Training Institutions meeting, which was held on the 9<sup>th</sup> of October, 1918. Travel restrictions had obviously not been put in place. Ibid. and *CE* November 1918, 163.

<sup>716</sup> In his report for the Hospital for the year, Macvicar reported "over 70" and referred to "70" in his later notes on the subject – amidst such conditions it is wholly understandable that the number count may not have been absolutely precise. 'The Victoria Hospital, Lovedale, Report for 1918', *CE* February 1919, 27; 'Notes on the Influenza Epidemic', MS 14,754 LC CL, [3].

them they covered the whole day, splitting their 12 hour shifts at 5 a.m. and 5 p.m., with Henderson taking the period from early morning into the afternoon, Roberts the evening to early morning shift, and Preston stepping in for breaks. As well as this active supervision, the students who were well enough to help joined in nursing other students. Additionally, Preston was active in matters of sanitation:

I [Macvicar] asked: How would we manage the sanitation? Mr Preston said: I will attend to that.... Mr Preston put beside each patient a sheet of paper, with a heap of sawdust upon it, to spit into. He arranged buckets at the far end of the classroom, behind a screen, into which bedpans &c could be emptied and he himself carried down and emptied those buckets morning and evening and changed the sputum papers.<sup>718</sup>

The provision of food for these Institution patients was under the management of Miss Christine Roberts.<sup>719</sup> In Macvicar's words:

...[she] had enlisted the help of a number of the Lovedale ladies. From this time on, as long as the place was in use, Miss Roberts sent out boys belonging to her own class each morning with a note to each housewife of what would be required of her and when, and the boys went round at the stated time with baskets to collect the dishes. This team work went on smoothly till the end.<sup>720</sup>

For good or for ill, these were the only members of staff that were involved in direct care for the sick students.

I was there at all hours and the only male members of the staff, European or Native, I ever saw in that large sickroom were Dr Henderson, Dr Roberts and Mr Preston and the only woman I ever saw was Miss Roberts. It was just as well the others kept out of it: they and their families seemed mostly to escape the infection or had it lightly.<sup>721</sup>

From Macvicar's writing, it is clear that he believed no further staff presence was needed – for their own safety and that of their families. One cannot help but be

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<sup>717</sup> Roberts, who worked at Lovedale from 1883-1920, went on to become a member of the Native Affairs Commission from 1920-1935 and a member of the South African Senate from 1920-1930.

<sup>718</sup> Macvicar, 'Notes on Influenza Epidemic', MS 14,754, LC CL, [1-2]. Macvicar's emphasis demonstrates that his pride in Preston's service was work which was typically left for servants or the students.

<sup>719</sup> Miss Roberts had been an Assistant Teacher at the Training School since 1913, and was the daughter of Alexander Roberts.

<sup>720</sup> 'Notes on Influenza Epidemic', MS 14,754, LC CL, [3].

struck by this seclusion of ‘the infected’ during a period of great uncertainty and upheaval on the one hand and other important instances of African Christians ‘gathering together’ amidst the crisis on the other.<sup>722</sup> In this particular situation with the Lovedale students, it soon became clear that there were notable differences of opinion with this aspect of the Mission’s treatment as felt by some members of students’ families.

One example provided by Macvicar demonstrates the variety of opinion(s) on a number of issues: quality of medical provision, parental rights, belief in adequacy of treatments, mission control and authority, consent and other matters of ethical concern, etc. In his later recounting Macvicar wrote:

I remember, one of the first days, hearing a commotion at the foot of the technical building stairs. Presently Dr Henderson came up, flushed and raised looking. A family had come demanding their boy who was upstairs in the classroom, very ill. Dr Henderson refused to let them take him home and would not let them up the stair

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<sup>721</sup> Ibid. See also, ‘The Victoria Hospital, Lovedale: Report for 1918’, *CE* February 1919, 27.

<sup>722</sup> Within African Christianity, one of the most obvious examples, in this particular regard, is seen in the beginnings of the Aladura movement in Nigeria, see H.W. Turner, *History of an African Independent Church I* (London: Oxford University Press, 1967), especially 1-17; for further revelation on this particular subject, see also: Robert Cameron Mitchell, ‘Religion Protest and Social Change: The Origins of the Aladura Movements in Western Nigeria’, in Rotberg and Mazuri, eds., *Power and Protest in Black Africa* (London: Oxford University Press, 1970), 458-496.

It should be noted, however, that this strong desire to draw together was not exclusive to those who left the Anglican fold. See, F. Melville Jones’ summary of events and opinion during the epidemic in his report: Minute V, “Yoruba and Hausa Missions, Report of Progress for 1918,” in *Minutes of the E.C. of Nigeria*, Document no. 31, G3 A2 O, 1917-1920, CMS Archives, held at University of Birmingham; or, in the words of a pastor or missionary serving in an area: “This arises from the closing of the churches down the country, and efforts were made to close our churches here, but I would not hear of it so long as people assembled in Mosque and market. *I think it was a mistake to agree to close the churches anywhere, it was a time for assembling ourselves in prayer.* Some of the heathen say our God is the God, as he saved the Christians, so few of them died comparatively, others say, no, the Christians are [sic: Christians are] witches and ought to be put to the test – poison drinking. I believe the church has comethrough [sic: come through] the trial of disease with faith strengthened, and that in the future many will join us because God answers prayer. [emphasis mine] “Minute XXXXI, Report of the Owo-Ora District, E.C. Jany. 1919,” 5, in *Minutes of the E.C. in Nigeria*, Document no. 31, G3 A2 O, 1917-1920, CMS Archives, held at the University of Birmingham. For a brief account of reaction within various missionary quarters in Zimbabwe (then Southern Rhodesia), from both blacks and whites, see Terence Ranger, ‘The Influenza pandemic in Southern Rhodesia: a crisis of comprehension’, in *Imperial Medicine and Indigenous Societies*, David Arnold, ed., (Manchester: Manchester University Press, 1988), 178-180.

to see him. He told them we could do for the boy what they could not do, and, besides, if they took him home, the infection would start from him and spread through the village. (The villages got infected later). The family became very excited but Dr Henderson resisted them fiercely and they had to go home without the boy. This happened more than once – I don't know how often.<sup>723</sup>

Several questions come to mind in analyzing this circumstance (while keeping in mind the very selective text available): Did the Institution and missionaries have the right – legally, morally, ethically, medically – to retain the young man in their care?<sup>724</sup> Or, to deny the patient's immediate family the right to at least see him? What of the patient himself – was he consulted on the matter? (One would most certainly assume not). In such a state of sickness and unexpected crisis, are such privileges waived?<sup>725</sup> Are there times when medical opinions on individual

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<sup>723</sup> Macvicar, 'Notes on Influenza Pandemic', MS 14,754, LC CL, [3].

<sup>724</sup> Paul Ramsey, *The Patient as Person* (New Haven: Yale University Press, 1970), 1-58. Ramsey is considered by many as the 'father of medical ethics' in its most modern academic sense.

<sup>725</sup> During the influenza pandemic, and notably within South Africa, there were numerous examples of 'delirium' or 'mental instability' cited by medical professionals, and with high fevers, mental capacities can certainly be affected; see, Macvicar, 'Notes on Influenza Epidemic', MS 14,754, LC CL, [3, 4]; 'The Influenza Epidemic', *CE* 8 November 1918, 170; 'Discussion on the Capetown [sic] Influenza Epidemic', *SAMR* 16 23 (14 December 1918): 354; Alexander Edington, 'An Investigation into the Nature and Etiology of the Disease hitherto known as "Spanish Influenza"', *SAMR* 16 23 (14 December 1918): 360. In Malawi, note the reaction of the Scottish missionary, Donald Fraser, in a write-up in his denomination's missionary periodical: "When war passed through Ngoniland, leaving our people puzzled and maimed, influenza followed close in its tracks cutting large swathes with its deadly scythe, and upsetting the mental balance of many. For the African is a very neurotic person, and the epidemic discovered his weakest point, leaving many half insane, and very depressed. Witch doctors found their opportunity, and these charlatans had an active time reaping a great harvest in fees. Their treatment did not calm their patients, or restore sanity. Rather, their wild dancing and nerve-racking equipment and shouts sent many over the border-line into complete madness, and these in turn became medicine-men also." 'Exit the Witch Doctors', *The Record* 1920, 180.

However, the case of the prophetess Nontetha Nkwenkwe demonstrates a startling example of the diagnosis of 'psychological problems' as an effort to quarantine a 'social problem', in the direct aftermath of the Influenza pandemic. See, Edgar and Sapire, *African Apocalypse*, 33-70.

One of the more striking examples within Macvicar's notes, in this regard, is a one sentence addition that he put into his recollection, coming right on the heels of his account at Lovedale itself: "The last patient to leave the class-room had to be taken straight to Fort Beaufort Mental Hospital. For days he had been off his head, a handful to manage". Macvicar, 'Notes on the Influenza Epidemic', [4]. This was the same hospital Nkwenkwe was sent to in 1922.

Though not related to the Influenza pandemic, but on the subject of Western psychology in the colonial African context and issues of power/authority, see Alexander Butchart, *The Anatomy of Power* (London: Zed Books, 1998), 111-127.



cases ought to be over-ruled by the demands of a patient or her/his family?<sup>726</sup> And if so, what are they? Does the whole interaction simply demonstrate the points of view that were often at odds with one another, and exacerbated during times of dramatic uncertainty: varied (if not opposing) virtues, systems of health care, religious perspectives, etc.?

In this specific case, the amount of source material available is so scant and one-sided that a full analysis would be lacking from the very beginning. Nevertheless, such questions have to be kept in mind and asked at appropriate and available opportunities, while also kept in the proper context of that time and place. Colonial regulations, such as those limiting movement during times of crisis, must be remembered, whether at a federal, municipal, or local level. Additionally, there were the missionary suppositions of ‘trusteeship’, effectively seeing themselves as morally responsible for those in their charge. And this theory of responsibility went even further, with regard to schooling, where notions of *in loco parentis* (‘in the place of the parent’) had longstanding and widespread precedent in British common law.

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<sup>726</sup> Such an ethical issue was raised with Dr Hope Trant, in her temporary work at the Methodist Mission hospital in Mahamba, Swaziland in the 1920s. In one particular case a man with an intestinal blockage was ready to undergo surgery (with his wife’s agreement), but whose younger brother did not consent and came with friends to carry his brother away from the hospital. According to Trant the missionary in charge of the station decided the matter: “His ruling was that if I felt I could cure the man, I should go ahead and operate, but if there was any doubt about his recovery, I had better let the brother take him. As the obstruction was already of some days duration, I could not promise a cure, so we reluctantly had to let him go back to his family, where he died.” Hope Trant, *Not Merriion Square* (East London: The Thornhill Press, 1970), 20. In such a case, the predominant factors in the decision making process included issues of authority within a mission; family’s wishes vs. the patient’s; the mission’s medical reputation; and community relations.

See also the personal insight and commentary regarding the ethics, cultural understandings and observances, and reputation of the hospital provided by Vane, as employed in the non-mission hospital for Africans at the Oriel mine hospital in the Transvaal during the 1930s and 40s: *Black Magic and White Medicine*, 65-70.

What is clear is that the Lovedale leadership, in its approach to the situation, relied heavily upon the opinion of the head of the Institution and its medical officer in deciding how to look after those in its care. In so doing, the young men and boys were treated on site, with the belief that the best medical care available during such a period was to be offered by maintaining seclusion and Western manners of palliative treatment.<sup>727</sup>

#### *The Girls' School*

While it may not have been unique to Lovedale, it seems that the influenza did not have as high a morbidity rate among the Institution's girls and young women as compared to the boys and young men.<sup>728</sup> Macvicar blamed this on the young men having been exposed to unfavourable conditions (cold and wet weather) when using the outhouses early on in their sickness.<sup>729</sup> A makeshift hospital for the young women was put together about a week after it had been organized for the young men (11<sup>th</sup> October), commencing on the 17<sup>th</sup> of October, and closed down earlier than the boys', on the 31<sup>st</sup> (as opposed to the 5<sup>th</sup> of November) – a notably short period of time.<sup>730</sup> The number of sick patients was nowhere near as many as with the boys, and the number of severe cases was probably smaller owing to the lesser number of

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<sup>727</sup> See below for specific treatments employed.

<sup>728</sup> One prominent medical journal, in its description of characteristics about the epidemic at the time, wrote, "The greater proclivity of men to contract the disease than women, observed in all previous epidemics, seems to have been about the same in this one." 'The Influenza Epidemic', *SAMR* 16 21 (9 November 1918): 318. The reliability of statistics available in such historical cases and, just as important, the reasons for ties between infection and gender susceptibility – i.e. genetically, socially, etc. – are unknown and would be very difficult to ascertain.

<sup>729</sup> Macvicar, 'Notes on Influenza Epidemic', MS 14,754 LC CL, [1, 6].

<sup>730</sup> Macvicar, 'The Victoria Hospital, Lovedale, Report for 1918', *CE* February 1919, 27.

young women and girls at the school, as compared with the number of males at the various schools.

The female staff of the school, including the Superintendent of the Girl's School, Miss Jessie Coombs, Miss Fan Balmer, and some of the African teachers, all participated in the nursing of the girls. It seems that the gender lines were largely intact in the treatment of the sick at Lovedale, with female staff treating the sick females and men treating the male patients (with the exception of Macvicar). All in all, in a short write-up on this portion of the work, Macvicar concluded, "The situation at the Girls' School was never so desperate as it was at the other two places".<sup>731</sup> Amidst all this sickness – with roughly 600 cases at the Lovedale schools having been infected – there were only four deaths, a mortality rate of less than one percent, a rate notably lower than average within South Africa.<sup>732</sup> Such good fortune for the vast majority of students and staff would have undoubtedly led to conclusions about the efficacy of treatment methods as well as feelings of Providential good will.

#### *Outwith Lovedale*

The rural villages around the town of Alice were infected a little later than Lovedale itself, following the typical patterns of this disease's dissemination. Thus, just as the temporary hospital quarters for the Lovedale girls were opened, on the 18<sup>th</sup> of October, operations were begun to treat people living in the immediate vicinity of

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<sup>731</sup> Macvicar, 'Notes on Influenza Epidemic', MS 14,754 LC CL, [6].

<sup>732</sup> Shepherd, *Lovedale South Africa, 1841-1941*, 330. By comparison, in Bloemfontein, Orange Free State, the mortality rate for whites was 2.7%, and 5.59% for blacks and 'coloureds', equalling 4.2% overall. Phillips, "The Local State and Public Health Reform in South Africa", *JSAS* 13.2 (January 1987): 222.

Lovedale, centred at the local African church-cum-temporary-hospital.<sup>733</sup> Here again, the room was cleared and patients were treated in the makeshift accommodation: men on one side of the room, women on the other side and children almost anywhere else. While Macvicar did not elaborate on why this may have been the case,<sup>734</sup> there were a larger proportion of women and children treated at this site compared to men: “Dr Henderson got the Native church cleared, installed the newly-acquired electric light, and got together a stretcher party of strong students who brought down patient after patient, some men, but mostly women and children, to the church.”<sup>735</sup>

The 74 patients treated at this site were visited twice daily by Macvicar and attended by some of the women of Lovedale. Mrs. Thomas Gibb (whose husband had been given leave to serve in WWI), oversaw much of the nursing during the day

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<sup>733</sup> This is a kind of vice versa scenario to the analysis brought up in the previous chapter, ‘the Victoria Hospital as sacred space’: ‘sacred space (church building) as hospital’. See chapter 4 for more.

This congregation became autonomous from the pre-existing Lovedale congregation in 1886. The Lovedale church congregation, for the Lovedale Institution community, consisted of various ethnicities – white, black, and ‘coloured’ – while this church congregation was for the Xhosa-speaking local population. Shepherd, *Lovedale South Africa 1841-1941*, 341.

The use of churches, as with the Lovedale Institution workshop and classroom, was not at all unique to the Lovedale example. For example, in Kwazulu-Natal there were similar responses on the part of missions there, using classrooms, and in the case of the Durban authorities, a beer-hall was converted into a make-shift care centre. See, Zondi, *Medical Missions and African Demand*, 238-261 (especially 255-256). In Bulawayo and Harare (then Salisbury), Zimbabwe (then Southern Rhodesia), when the lazarettos were at capacity, a town beer hall was also converted into a makeshift hospital for blacks, while a Drill Hall, Railway Institute, and at least one private home were used as temporary hospitals for whites. See, Michael Gelfand, *Tropical Victory* (Cape Town: Juta & Co., 1953), 204-207. For a more insightful and nuanced approach to this period, especially regarding black Africans, in Zimbabwe, see Terence Ranger, ‘The Influenza pandemic in Southern Rhodesia: a crisis of comprehension’, in *Imperial Medicine and Indigenous Societies*, 172-188.

<sup>734</sup> It seems probable that a large number of men were off working in locales away from home. Alternatively, there may have been other social factors among the men as to why they were not treated at the Lovedale church – an aberrant disease morbidity rate in this particular locale; an averseness to Western medical treatment, especially at a church; stronger resistance to the Lovedale young men coming with stretchers, etc.

<sup>735</sup> Macvicar, ‘Notes on Influenza Epidemic’, MS 14,754 LC CL [4].

and organised food for the patients, prepared largely by African women.<sup>736</sup> In addition, two Lovedale assistant teachers, Margaret Giles and Shena Macvicar,<sup>737</sup> were actively involved with some of the lay nursing, though at a certain point they both fell severely ill and had to stop.

Neil Macvicar's personal recounting of this particular episode of the pandemic is perhaps especially notable for the credit he gave to the educated African assistance rendered. One cannot help but think that he must have envisioned it as a successful rendering of his hopeful plan in an 'educated elite' taking an active part in matters of healthcare:<sup>738</sup>

...The Native Theological students helped splendidly, first at the hospital at [sic: and] now at the church....

Several had diarrhoea and being too weak to control themselves, the results can be imagined. Shena remembers Nggenje helping her to clean up one woman.

Day duty was bad enough, but where could we get anybody to face night duty? We were almost beat [word unclear] this point. I discussed it with the hospital matron, Miss Balmer. Several of the Native nurses were again on their feet and going on duty. We selected one who we thought might be able to manage it, Nurse Dora Jacobs. (Now and for many years head of the location service at Port Elizabeth: you will remember her vigorous, alert personality at the farewell meeting at the hospital). Nurse Dora went on duty that night and took charge every night from that time on till the church-hospital was closed. Every morning when I called she gave me her report. I could see she was tired but she never lost her grip of the situation.<sup>739</sup>

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<sup>736</sup> It is not clear exactly who these women were. Macvicar, 'Notes on Influenza Epidemic', MS 14,754 LC CL [4].

<sup>737</sup> As stated earlier, Shena Macvicar was an assistant teacher in the Normal department at Lovedale from 1916 to 1919; see pg 231 above.

<sup>738</sup> See chapters 4 and 7 for more on this theme.

<sup>739</sup> Macvicar, 'Notes on Influenza Epidemic', MS 14,754 LC CL, [5].

The parenthetical reference which Macvicar mentioned was from his retirement celebration from Lovedale in December 1937 (Macvicar wrote the notes, it seems, at Robert Shepherd's request, probably for Shepherd's centennial history of Lovedale). In an article reporting on that 'going away party', C.D. Zulu noted what Nurse Dora had been doing since her training at Lovedale – and in so doing, provides an intriguing insight into African response to Western trained nurses: "Mrs Dora Nginza (nee Jacobs), New Brighton Village, Port Elizabeth, completed her training in October, 1919, and went to do district work in New Brighton where she completes her eighteen years continuous service this year. When she began the work in Port Elizabeth the people were averse to her visiting them and actually called her "a ghost." (She believed the uniform party [sic: partly] responsible for

Of the 74 patients, thirteen died (nearly 20%). In what might be seen as typically optimistic or even a self-congratulatory statement on the efficacy of Western treatment, one account reported, “The seriousness of the work will be realized when it is added that thirteen deaths occurred in that church. A number of others were saved, who on admission were literally at death’s door.”<sup>740</sup>

#### *Village Hospitals and Local Response*

Yet one of the most intriguing aspects of Lovedale’s reaction to the Influenza Pandemic – and the glimpses of African response which ensued – was the result of temporary hospital establishments they set up, or attempted to erect, in villages surrounding Alice within the district of ‘Victoria East’. By the beginning of November the sickness was nearing the end of its run within Lovedale, but the outlying communities were no longer immune from the suffering. By the 5<sup>th</sup> of November makeshift ‘hospitals’ were started in schools and/or churches at Auckland,

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this.) She had continued against the opposition raised by the people until, today, she not only is acceptable but three other nurses, now employed in this village, are working happily and her name “ghost” has disappeared.” C.D. Zulu, ‘Tribute from Africans’, *CE* January 1938, 17-18.

One cannot help but note a couple of outstanding features in this brief write-up. The author cleverly avoided saying what else Nurse Nginza thought was the reason for the term used, and he did not provide any personal thoughts. It seems quite likely, though, that it was a pejorative term. With the knowledge that the name sometimes given by local peoples to Europeans – such as *mzungu* or *mlungu* – were the same for a spirit or ghost, I can only offer these conjectures, with the firm belief that more work needs to be done in this area: Could it have perhaps been in reference to death and the inadequacy of Western medicine (i.e.: ‘When this Western trained nurse (in white) shows up, someone often dies’)?; or, as a tool of Western medical imperialism (i.e. ‘She brings Western medicines at the expense/death of our ways’)?; or, perhaps she herself had ‘died’ (as a black African) and was now nothing more than an African white – a ‘ghost’?

Macvicar’s praise of Nurse Jacobs is similar, in a manner of pedagogical/mentor pride, also seen in Dr James McCord’s ardent praise of one of his black nurses during the Flu Pandemic (and who died as a result), Edna Mzoneli. See: James B. McCord (with John Scott Douglas), *My Patients Were Zulus* (London: Hamilton & Co., 1957; Panther Edition), 156-157.

<sup>740</sup> Macvicar, ‘The Victoria Hospital, Lovedale, Report for 1918’, *CE* February 1919, 27.

Dyamala, Ely, Gilton, Macfarlan, and Sheshegu.<sup>741</sup> Due to the swift severity of the epidemic's spread and the government's inadequate action during the crisis (never mind their lack of healthcare concern during the regular year), the Mission's work within this arena was the only example of Western activity bridging into some of the more traditional regions in this district.<sup>742</sup>



Photo of the Lovedale staff and student community who worked to care for sick members of Lovedale, as well as local populations in the immediate vicinity of the mission, during the Influenza Pandemic of 1918. While many details of the medical mission response, as well as local reaction, have been lost to history, this special sitting for a photographic shoot not only marks the magnitude of the event, but records the wide response given, especially by the young men of the Institution. Unfortunately, only the white staff personnel were listed on the back of the photo. The second row (the first seated row behind the sign), beginning with the woman 5<sup>th</sup> from the left side of the photo: “Miss Coombs, Mr Kerr, Mrs Gibb, Mrs

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<sup>741</sup> Macvicar, ‘The Victoria Hospital, Lovedale, Report for 1918’, CE February 1919, 27; ‘Hospital Work in the Native Villages of Victoria East’, CE December 1918, 185.

<sup>742</sup> The area covered by this activity was roughly from 15 miles to the north of Lovedale and about 10 miles to the south.

Geddes, Dr Roberts, Mrs Henderson, Dr Henderson, Shena Macvicar, and Mr Chalmers.” Note the absence of Dr Macvicar.<sup>743</sup>

Upon having served in varying medical assistant capacities within Lovedale and amongst the local village of Utselamanzi, young men from the Lovedale Institution and the South African Native College at Fort Hare took charge in managing these makeshift hospitals.<sup>744</sup> The men were sent out to visit homes in villages and rural areas, in an effort to collect the more serious cases together at the improvised hospitals. Teams of four, two working during the day and two during the night, were organized and these care workers oversaw basic medical attention, feedings, nursing, and prepared reports on the patients for visits from Macvicar and hospital nurses (who visited ‘every few days’).<sup>745</sup>

One of the important expressions of the aim in this medical mission came, not in its impact upon the outlying community but in the effect that this work had upon the young African student-workers. ‘Christian character’ had long been a buzzword, of sorts, amongst many missionaries as they sought to ‘civilize’ their African charges. And just as Macvicar expressed profound joy in the work ethic of Nurse Dora Jacobs, so too was there an expression of deep satisfaction in ‘Christian maturation’ over the effort put in by the students, marking the traits which the

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<sup>743</sup> Photograph 1153, [c. 1919], Lovedale Pictures, CL LC.

<sup>744</sup> No explicit mention was made as to why it was just young men sent out during this period, but would have undoubtedly been seen as improper to send out young single women for such a task, even if they were more qualified in nursing procedures.

<sup>745</sup> ‘The Victoria Hospital, Lovedale, Report for 1918’, *CE* February 1919, 27; [Macvicar], ‘Hospital Work in the Native Villages of Victoria East’, *CE* December 1918, 185. While the authorship of this article is not explicitly attributed to Macvicar, I believe it to be so.

The medical attention given was probably altogether very basic – including the regular taking of temperatures, water sponge-ings (in an effort to reduce temperatures), helping to feed, and



missionaries saw as paramount in Christian development (and duly absent in most Africans):

These men were willing to do what they could.... The result of the work upon the character of the orderlies, who were volunteers and asked no payment for their services, was most apparent. It has developed self-reliance and the spirit of helpfulness; and not a single grumble or complaint was made by any of them. In several cases it seems to have made men out of boys.<sup>746</sup>

While the missionaries and community of Lovedale took pride in their students' service and evaluated the labour performed as Christian-minded, the medical relief work itself was not welcomed by some Africans in the district. Though an article from *The Christian Express* does not provide specific details regarding these reactions and it is clearly told from a missionary perspective, the account still provides revealing insights for analysis on varying levels:

An attempt was made to help the people of Gaga, Gqumahashe, and Kwezana, but partly because the epidemic had in great measure spent itself in these villages and partly because of the passive resistance of the people themselves, not welcoming help, the men were recalled....

Perhaps the saddest experience, however, was to see the distrust and lack of confidence at first shown by the Natives towards the Europeans. They could not understand why the white man had suddenly grown so solicitous for their welfare. This is a terrible impeachment of our attitude towards the Native races, that they could not believe us capable of helping them even in such a season of calamity unless we had behind it some scheme of bettering ourselves. Do the Europeans deserve such distrust? Is there anything in our past treatment of these people to create such suspicion and fear? We ought thoughtfully to ask ourselves this question. In one village in a public meeting at the kraal gate the men demanded a definite answer, yes or no, to the question: Would Government force them to pay for the help that was offered to them? And when they were informed that Government had no such intention,<sup>747</sup> the first patients to be received into the hospital would give no names, and had to be identified by numbers, or gave fictitious names. Whilst this

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administration of any medicines. Unfortunately, Macvicar provides very little testimony on the medicines and/or specific treatments he employed during this outbreak.

<sup>746</sup> 'Hospital Work in the Native Villages of Victoria East', *CE* December 1918, 185.

<sup>747</sup> While the government had not prepared for such an occurrence and paid little attention to rural African health matters, to the credit of the Divisional Council of Victoria East (the local government) a financial agreement had been reached with the Victoria Hospital to mitigate costs. For one of the most detailed accounts of governmental response within South Africa see Howard Phillips, 'The Local State and Public Health Reform in South Africa', *JSAS* 13.2 (January 1987): 210-233; *Black October': The Impact of the Spanish Influenza Epidemic of 1918 on South Africa* (Pretoria, Government Printer, 1990). This latter work is Phillips' later publication of his Ph.D. thesis from the University of Cape Town in 1984.

distrust was a fairly common experience, there were occasionally cases where the feeling was so strong that it verged on madness. For example in one village on the first day that the orderlies were visiting the huts a man was going round before them, telling the people that this disease was a device of the Europeans to finish off the Native races of South Africa, and as it had not been quite successful, they were sending out men with poison to complete the work of extermination.<sup>748</sup>

More clearly than most reports on the medical work of the mission, this account seems to demonstrate that attitudes toward the mission greatly varied amongst assorted communities. The crisis which the influenza brought – quick onset and infections, high morbidity rate, higher than usual mortality (especially amongst the typically healthiest) – perhaps produced stronger than normal reactions by the people, especially due to uncertainty and manifest stress, as in the reactions from the communities of Kwezana, Gqumahashe, and Gaga.

More than this, however, is the overarching feeling of mistrust and outright hostility toward the missionary presence as a European tool for the destruction of Africans.<sup>749</sup> For this missionary publication to say that, “this distrust was a fairly

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<sup>748</sup> ‘Hospital Work in the Native Villages of Victoria East’, *CE* December 1918, 185.

<sup>749</sup> A similar occurrence took place with some of the Scottish Presbyterian missionaries in I’Chang in China during the pandemic. Thomas Kearney later recalled that at the time the mission’s doctors believed quinine would prove an effective medicine for the sick (incorrectly), though this was accepted as true within the Western medical community at the time. Due to its high price the mission appealed to local merchants, who were not Christians, and they raised the necessary funds for its free distribution. One of the evangelists, presumably a Chinese individual, distributed the quinine in surrounding villages and encountered resistance, most notably in one village in which the sickness had taken an especially heavy toll. According to Kearney, “I remember an evangelist telling me afterwards that he was deeply suspected in one village to which he had gone. Why should any one come and offer them precious medicine without money and without price? They suspected he was dealing out poison to them!” Thos. R. Kearney, ‘Merchants and Missionaries’, *Other Lands* 11, no. 43 (April 1932): 82-83. Note also the opinion/recount of a white writer, M.H. Wilson, from South Africa, who wrote in a rather paternalistic manner of African responses to the influenza, while espousing some ‘efficacious’ results of white reaction and treatment: “Enlightened men were running about to get medicines and were thus able to save many of their loved ones. The heathen were often using, and pinning their faith to, useless nostrums that could not help, or sitting down in helpless ignorance. Others said that the medicines brought to them were intended to poison, or believed their children were bewitched by evil disposed persons.” ‘Lessons from the Influenza Epidemic’, *CE* December 1918, 186.

Though not involved with missionary medicine at that particular point in her career, Hope Trant relates the fervent hostility of Africans to a medical survey she was in charge of, which included taking blood samples. It was believed that the blood being drawn by the medics was then being drunk by the surveyors, as one man had witnessed wine being drunk in their homes and mistook this dark

common experience” seems to reveal a rather wide gulf between Lovedale and white authorities, on the one hand, and these outlying African communities on the other. From afar, this is a rather striking appraisal of some local opinion on a missionary presence which had been in the area for nearly 100 years at that point in time.

It may also highlight a division between communities which saw themselves, or were recognized, as ‘Christian’, or at least sympathetic to elements of the Western system, and those which did not. This is not to say, however, that there was a whole or complete break between the competing systems of healing and healthcare. While Western practitioners, like Macvicar, hoped for a comprehensive break from ‘superstitious’ and ‘ineffective’ African beliefs and practices (which was largely his perception of African health practices), the reality was that for many, it was not ‘either/or’, but ‘both/and’. Though Macvicar often derided the system of belief in African traditional methods of healing, and worked to try to replace such belief and custom, even his own writings on the subject make clear that many Africans he himself treated were pluralistic in their approach and acceptance of healthcare systems.<sup>750</sup> As such, even those who may have been identified as ‘Christian’ (individually or communally; imposed internally or externally) – used as a term to designate adherence to Western manners and mindset – were often willing to

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red substance for African blood. For her very insightful comments, both on varying European practices and reactions as well as African thoughts, see her chapter, ‘Drinking Blood’, in *Not Merriem Square*, 127-143.

<sup>750</sup> See his chapter, ‘Things that happen in a Christian village’, in *Side-Lights Upon Superstition*, 6-10. Still further, note the answers given by Macvicar’s informants on the subject of “kafir poisoning and witchcraft”: “Q. [Question] About what proportion of all deaths are attributed to witchcraft? A. [Answer] About half in a Christian village; in a heathen village about all.” Ibid., 29.

patronise, incorporate, or take on the European methods of healing into their own system, while still maintaining strong undercurrents of traditional African belief.<sup>751</sup>

But how did the missionaries respond to the African reaction of distrust and/or refusal? They were perplexed at the notion of the African declining their charity, unable to comprehend, first of all, why the villagers would not want ‘superior’ medical aid, and secondly, why *they* would not be trusted. More than this, however, was the sobering conclusion they reached. Their deduction centred on what they believed was the dire width and depth of the poverty (and associated ills) within the surrounding area:

We suppose this attitude of mind is ultimately attributable to grinding poverty. The struggle for existence has become harder than even those of us most familiar with Native conditions have hitherto realised. The unselfishness of the poor is proverbial, but there is a stage in a bitter struggle for existence at which even this proverbial unselfishness is crushed out. In these days we have seen many indications of this. The dread of any fresh imposition by Government of a burden that to a European would seem insignificant was also a revelation of anxious bitter poverty. Some villages were much poorer than others, and in some the normally prevailing poverty was accentuated by [recent poor harvests]... the rule was want, varying only in degree.<sup>752</sup>

The Lovedale community had certainly been aware of such circumstances,<sup>753</sup> but the influenza pandemic highlighted the conditions in the villages, especially for members of the mission who had not had as much contact with the rural African population in their domestic settings. Unsurprisingly, some wove a religious thread in the

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<sup>751</sup> For a thorough study on this aspect of health and healing, within the contemporary Malawi setting, see John Lwanda, *Politics, Culture and Medicine in Malawi*, especially 171-280.

<sup>752</sup> ‘Hospital Work in the Native Villages of Victoria East’, *CE* December 1918, 185.

<sup>753</sup> Espousing their role as liberators, educators, and healers – echoing British middle class attitudes to the lower class – just a few years earlier the following was written in a section on the role and work of the Victoria Hospital: “The causes are partly in the power of the people to remove and partly not. They need advice. They also need help. As in other countries the ultimate causes of these preventable diseases are to be found in poor social and sanitary conditions. Poverty, overcrowding, infected drinking water, poor food, drink, ignorance, and carelessness on the part of mothers in feeding and tending their children – these are the evils which here as elsewhere combine to work the physical ruin of a people.” ‘V. The Hospital, Its Work and Its Opportunities’, *CE* July 1916.

circumstances while also reinforcing their opinion on the importance of their work and presence:

If the epidemic had done nothing more than teach us a new sympathy with a condition of things of whose distressful nature we mistakenly thought we knew enough before, it has not failed of a Divine purpose. The remark of one visitor to the stricken areas was, 'I always believed these people needed the missionary, but I feel it to be true a thousand times more to-day.'<sup>754</sup>

This last statement, though anonymous in the article, was probably made by Henderson, the principal of Lovedale. The poverty he witnessed in these outlying homes had a direct correlation to some of his work in the next decade of his life (which turned out to be his last). Within the realm of local government involvement, Henderson participated in the Magistrate's Relief Committee during the drought of 1926-1928 and was Chairman of the Public Health Committee for the Alice Municipal Council, bringing relief supplies to the local populace and a more thorough perception of the true condition of rural Africans in the region to the council. As a part of missionary health-related endeavours, Henderson's work included his Chairmanship of the Victoria Hospital Board, membership in the Committee of Management for the South African Health Society and the Lovedale Social Service Committee, and from 1925 a central role in the formation and running of the Ciskeian Missionary Council.<sup>755</sup> Though the impact of some of these committees is difficult to ascertain, another role connected to this outcome was Henderson's writings on the social conditions of these rural Africans, often through

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<sup>754</sup> 'Hospital Work in the Villages of Victoria East', *CE* December 1918, 185-186.

<sup>755</sup> Macvicar, 'Social Service and Health', *SAO* September 1930, 179-180; Shepherd, *Lovedale South Africa 1824-1955*, 82-83.

the *South African Outlook*, as attempts to inform the public and pressure governmental policy.<sup>756</sup>

The Influenza Pandemic certainly provides a lens through which to view varying aspects of the missionary medical enterprise. At Lovedale, the crisis brought to life a response which was not at all restricted to the medical personnel. Rather, students and staff alike engaged in nursing and basic care-giving, both within and outside the geographical parameters of the mission. And as limited as the material may be, this particular event in medical history provides at least a hint of the varied reactions and responses, of black African voices, as well as fellow sufferers.<sup>757</sup>

## Concluding Remarks

Macvicar's confidence in Western biomedical advances can be seen as an embodiment of wider optimism amongst many within the medical community of his day. Though writing specifically about Germany, Sheldon Watts' words nevertheless summarize very well this fervour:

Between 1840 and 1910, for the first time ever, there was a coming together of several distinct strands of thought. These eventually resolved themselves into the single strand which held that true scientific knowledge of each specific disease causal agent and its relationship to humankind would, in the not too distant future,

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<sup>756</sup> See especially, "The Problem of Native Poverty", in which he centred blame with European imposed systems for African economic problems and that what relief was brought by governmental entities accomplished little in terms of proper and longstanding social, economic, and health care improvements. *Christianity and the Natives of South Africa: A Year-Book of South African Missions*, compiled and edited by J. Dexter Taylor, ([Lovedale]: General South African Missionary Society and The Lovedale Institution Press, n.d. [1928]), 24-32.

<sup>757</sup> Roy Porter, 'The Patient's View': 183-185.

bridge the age-old gap between medical theories and effective therapeutic practice.<sup>758</sup>

As such, it is no surprise that Macvicar was heartily engaged in a wide array of work as a missionary physician, both medical and surgical. If the hospital, as discussed in chapter 4, was the epitome of the Western location for healing and curative power (certainly in the eyes of the missionaries, if not always the locals), it was the actual medical practices which were of ultimate importance. While surgery was not the mainstay of Macvicar's work, it was utilised by him, most especially in his early years, as a biomedical technique *par excellence* in demonstrating to patients one of the 'superior' aspects of Western medicine.<sup>759</sup> This surgical work in his early years may be of special note as a way of making a notable impression upon the local African population, especially because surgical work at Victoria Hospital was never promoted until the arrival of Shena Macvicar, a quarter century after Neil Macvicar first started his work at Lovedale.

While there have been longstanding perceptions of medical missionaries as second-rate in their capacities as medical men and women,<sup>760</sup> Macvicar certainly defied this assessment. As a student he was awarded prizes for his work at the University of Edinburgh,<sup>761</sup> and over the years his scholarly contributions to the field of medicine only grew, especially in the field of tuberculosis. This emphasis upon furthering the scientific knowledge of disease and medical understandings of health are an important hallmark in his approach to the work of medical missions. For

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<sup>758</sup> Sheldon Watts, *Disease and Medicine in World History* (London: Routledge, 2003), 109.

<sup>759</sup> With Macvicar, this was especially the case with eye surgery, most notably with the removal of cataracts.

<sup>760</sup> Grundmann, *Sent to Heal!*, 37.

<sup>761</sup> Shepherd, *A South African Medical Pioneer*, 10-23.

Macvicar, the importance of contributing to academic or professional knowledge, in this case in the field of medicine, was a vital part of a responsibility to join in the progress of humanity. If he viewed one aspect of his Christian mission as the civilising of Africans, ‘pulling them up’ to the standards and manners of the West, an equally important aspect was his desire to advance, or ‘push forward’, the understandings of Western medicine.

For all the progress within biomedicine, the fact remains that during this period before anti-bacterial advances, medical knowledge and techniques as practiced by the Victoria Hospital personnel were sometimes far from successful. Even with terribly limited understandings of the epidemiological dynamics of the influenza virus during the 1918 Pandemic, however, many within the Lovedale community, especially male students, were led by Macvicar in working hard to provide palliative – and curative, where possible – care. And this labour was carried out both for the people of the mission as well as the surrounding communities during the emergency.

This health crisis, unlike anything encountered in modern history, provides the historian of medical missions an important window in response and reaction. In the case of Lovedale, the most significant aspects for this study come in the mission reaction to African response, as well as what I believe is a long term local response to the mission’s work during the crisis. The mission’s leadership was surprised at the lack of trust exhibited by some local villages to their offers of help in establishing and running ‘site hospitals’. This demonstrates a clear disconnect between the mission personnel and the reality of the local perceptions of them, exacerbated though this may have been in the crisis. And this is all the more telling, considering



the longevity of Lovedale's existence in the area. However, in the years following the pandemic, the number of patients visiting the hospital increased to such an extent that it clearly demonstrates an increased local acceptance of mission medicine, due in large part, I believe, to the mission's medical care during the 1918 Pandemic.<sup>762</sup>

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<sup>762</sup> Note especially the enormous response in the year following the Pandemic, setting a record: 'The Victoria Hospital Report for 1919', *CE* February 1920, 28.

## Chapter 6: Macvicar and Higher Education

### **Introduction**

As demonstrated in the previous chapter, the actual practice of Western biomedicine both against ill health and disease as well as in opposition to African traditional methods of healing maintained a central role in the medical missionary vocation. In addition to this fundamental aspect of the occupations of a mission nurse or doctor, another important function for many in Sub-Saharan Africa was an involvement within the educational sphere of mission work.

The pedagogical endeavour itself was often almost exclusively tied to the missionary presence within vast areas of Africa and Asia, especially in the 19<sup>th</sup> century, though also well into the 20<sup>th</sup> century.<sup>763</sup> The South African educator, Dr Jean van der Poel, at points a rather fierce critic of the missionary purpose and role in educating South African blacks, nevertheless conceded that the widespread foundation for education was due to missionary labour:

The credit for its initiation and for much of its statistical growth must be given to the missionaries. The discredit for its dismal failure to lift the mass of the Natives from illiteracy and to provide further education for those whose intelligence entitles them to it must be laid at the door of the Government and of white South Africa, whose racial prejudices and economic jealousies are reflected in the policy of the government.<sup>764</sup>

If some have been at turns critical of the methods or intent of the missionary role in education, for many of those within the Scottish Presbyterian tradition, education

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<sup>763</sup> Etherington, 'Education and Medicine', in *Missions and Empire*, 261-275.

<sup>764</sup> Jean van der Poel, 'Native Education in South Africa', *JRAS* 34, no. 136 (July 1935): 329-330.

was a dear, longstanding, and vital aspect of their missionising scheme.<sup>765</sup> Indeed, the issue of educating – ‘enlightening’ – people in preparation before their conversion was a central part of heated foreign missionary discussion as far back as the 1796 Church of Scotland General Assembly.<sup>766</sup> Within the 19<sup>th</sup> century, during “the era of mission education”<sup>767</sup> on the African continent alone, Lovedale (South Africa), Blythwood (South Africa), and Hope-Waddell (Nigeria) were mission schools so significant that one Foreign Mission Committee later wrote, “These two first institutions have been Scotland’s greatest contribution to South Africa.”<sup>768</sup> This sentiment echoed the importance of education within the discourse that James Stewart offered in his Duff Missionary Lectures at the beginning of the 20<sup>th</sup> century: “Where the missionary goes, the school soon follows.... and among peoples such as those of the African continent, Christianity becomes the Universal Educator as well as Civiliser, since civilisation starts from and advances with education.”<sup>769</sup>

After the United Free Church of Scotland was given control of the Basel Mission’s work in Ghana, then known as the Gold Coast, in the latter portion of

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<sup>765</sup> Sheila M. Brock, *James Stewart and Lovedale* (Ph.D. Dissertation, University of Edinburgh 1974).

<sup>766</sup> Elizabeth G.K. Hewat, *Vision and Achievement 1796-1956* (Edinburgh: Thomas Nelson and Sons Ltd., 1960), 1; Natasha Erlank, “‘Civilizing the African’: The Scottish Mission to the Xhosa, 1821-64”, in *Christian Missions and the Enlightenment*, ed. by Brian Stanley (Grand Rapids: William B Eerdmans Publishing Company, 2001), 141-168.

<sup>767</sup> Jonathan D. Jansen, ‘Curriculum as a Political Phenomenon: Historical Reflections on Black South African Education’, *Journal of Negro Education* 59, no 2 (1990): 195. Jansen maintains there are five periods of education within the South African context: ‘traditional African’; ‘slave’; ‘mission’; ‘Native’; and ‘Bantu’.

<sup>768</sup> *United Free Church of Scotland Report on Foreign Missions Submitted by the Foreign Mission Committee* (Edinburgh: United Free Church of Scotland, 1929), 26.

<sup>769</sup> James Stewart, *Dawn in the Dark Continent* (Edinburgh: Oliphant Anderson & Ferrier, 1903), 178-179.

World War I, the Reverend A.W. Wilkie<sup>770</sup> was ‘lent’ to oversee their new sphere of influence. In an interview with his church’s missionary magazine for readers back home, Wilkie noted some of the differences between the UFC’s work in Calabar and what had been the Basel Mission’s approach in Ghana, most particularly the role of the school and education. His quote illustrates well the Scottish fundamental focus on schooling:

[Interviewer]: ‘What, then, was the character of German Mission work?’

[Wilkie]: .... ‘The centre of all the work, and the strength of it, was the little village church. The missionaries bought land extensively upon which the Christians – leaving the heathen community – settled: the nucleus of a Christian community. Schools might follow, but the church was the starting-point. Now, in Nigeria, the nucleus of our work is usually the village school. We start with that, and use it to approach and win the confidence of the people. Then come the Church and the Christian community.’<sup>771</sup>

This educational role, even within full missionary teams, was not restricted to teachers or assistants, as witnessed earlier with Dr Jane Waterston, in which the medical doctor spent a great deal of time teaching young pupils at the behest of Dr Robert Laws, himself a physician, who largely devoted his time to other realms of mission work.<sup>772</sup> And for more solitary and pioneering medical missionary figures like Dr John Hitchcock, of the Calabar mission in Nigeria, educative roles consumed a great proportion of his time thereby taking away from what could have otherwise been dedicated to medical work. During his time in the remote Uburu station, which had been specifically chosen for the impact it would have through a medical practice, Hitchcock’s duties included additional realms of work including preaching,

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<sup>770</sup> Rev. Wilkie had been with the Calabar mission in Nigeria for 17 years and later became Principal of the Lovedale Institution after the death of Rev James Henderson in 1930.

<sup>771</sup> ‘Editorial Interviews: Rev. A.W. Wilkie, M.A., B.D., Gold Coast’. *The Record* (1919), 260.

<sup>772</sup> This is not to overlook the gender discrimination issue with Laws’ attitude to Waterston. See chapter 2 for more on Jane Waterston’s time at the Livingstonia mission in Malawi.

administrative tasks, meeting with chiefs, mitigating disputes, as well as teaching and managing pupils and teachers within the district.<sup>773</sup>

In light of this Scottish mission background and the aspects of his career covered previously in this thesis, it is no surprise that Dr Neil Macvicar was also heavily involved with varying aspects of education. This chapter centres on his attitude toward and work within assorted levels of education – governmental, societal, public health, and medical – within southern Africa, particularly focussing upon the formation of the South African Native College (SANC),<sup>774</sup> and the closely related subject of higher education for African medical personnel, particularly medical assistants.

### ***Mission Based Medical Education***

In chapter three I discussed the role which Macvicar envisioned for an educated elite within African society, especially as it related to his purpose in eradicating and replacing African traditional beliefs which he found unenlightened. Views which accredited the cause of ill health or other physical maladies to witchcraft or various supernatural entities were seen as the root of a host of problems which Macvicar and others sought to change. However, while these societal conceptions and efforts to transform them are an important element of the historical study of the medical

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<sup>773</sup> Though typical of its time and manner, in one of the worst ways, Livingstone's hagiography of Hitchcock is nonetheless informative on a host of issues, with much to be gleaned from it, especially material from Hitchcock's personal writings. W.P. Livingstone, *Dr. Hitchcock of Uburu* (Edinburgh: Foreign Mission Committee of the United Free Church of Scotland, 1920).

<sup>774</sup> The institution which was eventually to become Fort Hare University, was previously known by a number of names. In the earliest period it was referred to as the, 'Inter-Colonial Native College' and the 'Inter-State Native College' before the more typical 'South African Native College'. I will typically refer to it in the latter form.

missionary effort, equally significant is the story surrounding the education of black African men as medical assistants, and not as medical doctors.

### *Blantyre*

Previous to his appointment to Lovedale, Macvicar's work with the Church of Scotland Blantyre mission in Malawi was especially important for the way in which it shaped not simply his views of Africa on the whole, but Africans themselves and his missionary purpose. Heavily influenced by the liberal-minded D.C. Scott (who was head of the Blantyre mission at that time) and interactions with African medical pupils and friends, Macvicar wrote boldly about his great hope for Africa. Though couched in the typical paternalistic attitude of its day, which saw black African societies as emerging from more 'basic' states, Macvicar's thoughts on the ability for education to transform the continent are noteworthy. In a brief editorial in *Life and Work in British Central Africa* on noteworthy strides and accomplishments within Japanese culture, the author then turned to matters of medicine and education, and hope and pride in Africa's potential:<sup>775</sup>

Within a generation they [the Japanese] have brought themselves up to date in European medicine and surgery as well as in European military and naval warfare. The University of Tokio [sic, as below] is as well equipped as that of Berlin, and that is saying the best that can be said. Original work is being done as good as any in Europe.

How soon will the natives of British Central Africa bring themselves abreast of Europe, and thus be able to do original work? It is being at the growing edge of things, even of one or two things! We do not, with some people, doubt their ability to do this. One of the best students of medicine we ever met was a pure negro from the West Coast. If only the idea took possession of one or two minds, there is, so far as we can see, no lack of ability or even of application to carry it out. It is a little

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<sup>775</sup> While I cannot say with absolute certainty that this brief piece was written by Macvicar, the probability is quite high. The immediately previous two writings in this issue were both on medical/health related subjects, 'Rinderpest' and 'The Great Plague', of which the latter centred on four great medical scientists: 'Knights Hospitalers' (one of whom was Japanese). It is, in my view, highly likely that Macvicar authored the piece. And even if, by chance, it was written by Scott, it is something to which Macvicar would have acceded.

more education, a little more widening of the view that is still required, and then will dawn the idea and the enthusiasm will come with it. Then shall we have at Blantyre a University that will compare even with Tokio or Berlin!

The Japanese did it in a generation, though of course they had a better start. Yet it may even be done here in a generation. May this be the happy generation, for much good will come of this.<sup>776</sup>

This article demonstrates his belief in the latent ability within the black African ethnic group, if not an unbridled optimism in the expectation of progress which they believed European education brought with it. In his view, black Africans were neither held back by a racial (what we might call ‘genetic’) disposition in which resided an inability for wholesale advance, nor did he limit the potential of advanced learning to a small number of remarkable individual Africans, as some eugenicists of this period did.<sup>777</sup> While they believed that self-imposed societal beliefs, such as witchcraft, as well as unchangeable geographical conditions, such as the Saharan desert mitigated societal advances, Macvicar and others like him were confident that their presence and work was bringing with it a civilising process.<sup>778</sup>

This belief in the ability of Africans to learn and be able scholars and medics was not simply theoretical or untried, and it was the Blantyre experience which shaped Macvicar’s mindset, due largely to two men. As head of the Blantyre

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<sup>776</sup> *LWBCA* nos. 111, 112, 113 (May, June & July 1897): 7. Note: this single issue comprised all three months.

<sup>777</sup> Thomas F. Gossett, *Race* (New York: Schocken Books, 1965), 155-156.

<sup>778</sup> For more on Macvicar’s thoughts regarding “Bantu civilisation”, see his pamphlet, *Western Civilization and the BANTU*, which was published near the end of his life (a full fifty years after the above quotation) in the New Africa Pamphlet series published by the ‘liberal’ South African Institute of Race Relations. He believed, for instance, that geographical conditions such as the lack of numerous fringe islands along the Sub-Saharan coast impeded the ability of any ship building, and therefore the cross-cultural contacts and ‘advancements’ which often ensued in the interaction with other ethnic groups, *Western Civilization and the BANTU* (Johannesburg: South African Institute of Race Relations, 1947), 20-21.

This work by Macvicar is doubly important for the echoes it produces from earlier influences, especially Henry Drummond. See especially, Henry Drummond, *Tropical Africa* (London: Hodder and Stoughton, 1888); *The Lowell Lectures on The Ascent of Man* (London: Hodder and Stoughton, 1897).

mission, D.C. Scott guided Macvicar's younger mind to a fairer and more optimistic attitude toward African individuals and culture alike<sup>779</sup> (not to mention Scott's influence theologically), and in the African, John Gray Kufa, Macvicar found an able medical pupil, friend, and (according to Scott): the "ideal of a man".<sup>780</sup> Indeed, Kufa became such a close friend and presumably trusted confidant to Neil Macvicar and Jessie Macvicar (nee Samuel) that for their wedding at Blantyre on 19 February 1898, the local missionary magazine recorded: "The bride [Samuel] was attended by Miss Macvicar [Bessie, Neil's sister who was serving at Blantyre] who acted as bridesmaid, while she was given away by John Gray Kufa, Dr. Macvicar's senior hospital assistant."<sup>781</sup> It is no less than extraordinary that Kufa – a black African medical assistant who had been Macvicar's student – would give away a white nursing sister when there were other more 'senior' white mission figures around.

It was due to the academic and medical ability of Kufa, and others such as David Mothela<sup>782</sup>, which allowed the mission's magazine to write with such enthusiasm for the future in the waning years of the 19<sup>th</sup> century:

The Hospital idea and the development of medical work under Dr. Macvicar and Sister St. Luke {the name Miss Samuel has now adopted} has taken a very firm hold, and the idea of training doctors for distant spheres is a promising one and one successfull [sic] elsewhere.

We shall have a central medical school by and bye.

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<sup>779</sup> Ross, *Blantyre Mission*, 127.

<sup>780</sup> Quoted in Ross, *Blantyre Mission*, 127. This is what D.C. Ross was quoted as saying about how Macvicar felt regarding Kufa.

<sup>781</sup> *LWBCA* no. 121 (15 March 1898): 1.

<sup>782</sup> Mothela was another medical assistant trainee of Macvicar's at Blantyre: "David Mothela (from Domasi) has passed his final examination upon the course of lectures prescribed for Hospital assistants, and has received his certificate. We heartily congratulate him. His success is the result of nearly two and a half years steady work. He is the second of the Hospital attendants who has mastered this difficult course of study. He is shortly to leave for Domasi to take charge of the Dispensary there." *LWBCA*, no. 136 (June 1899): 2.



The same development seems possible in accountant work, and the boys are taking to it in a way which augurs well for a staff of capable men.<sup>783</sup>

Such attitudes clearly reveal the optimistic tone toward education's role, especially medical, in the mission's attempt at incorporating the black African into the standards and norms of Western 'civilisation'.<sup>784</sup>

The medical instruction at Blantyre prepared 'Hospital Attendants and Dressers' and normally took eighteen months to complete. According to Macvicar's published lecture notes, the course sought to prepare the young men to run dispensaries in the outlying regions from the central mission stations;<sup>785</sup> the medical work was to be performed in addition to their other roles within the life of the church, such as evangelism. Years later Macvicar remarked that the scheme did not live up to its initial hopes, but that this was not because of the men themselves. Rather, he reasoned that very few of their fellow Africans went to these medical assistants for care, something which he would have likely accorded to the locals' lack of basic health knowledge. Nevertheless, along with Macvicar, this handful of medical men managed to vaccinate approximately 30,000 after a smallpox outbreak. And after Macvicar's departure, many of these medical assistants went on to work in varying facets of health care, from private companies who employed them to treat their African labourers to governmental health services in neighbouring territories.<sup>786</sup>

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<sup>783</sup> *LWBCA*, no. 108 (February 1897): 9.

<sup>784</sup> P.A.W. Cook, 'Non-European Education' in *Handbook on Race Relations in South Africa*, ed. by Ellen Hellmann (Cape Town: Oxford University Press, 1949), 348-354. Though now dated, Cook provides a succinctly capable overview, with statistics especially relevant to the turning point in South African politics and society at that time.

<sup>785</sup> This book was published by the Blantyre mission circa 1898, approximately 200 pages long; very few extant copies exist.

<sup>786</sup> Macvicar, 'Memorandum on the Training of Native Medical Assistants', LC CL, PR 3085, 1-2.

Later in life, Macvicar, writing in the midst of heightened apartheid and the growth of varying ideologies declaring the inferiority of blacks and other ethnic groups within South Africa (and beyond), commented on his influences, experience, and conclusions regarding the education Africans as medical personnel.

As a boy of 17, from the books of David Livingstone and other travellers I gained the impression that the people of Africa had qualities much higher than opinion generally gave them credit for, but that they had never had a fair chance.

.... During all those years at Blantyre and Lovedale, I was in daily close contact with African people as medical missionary, and as teacher at Blantyre of male hospital assistants, and a [sic: 'at'] Lovedale of Nurses. My experience entirely confirmed the impression I had gained from Livingstone. I found the Africans to be no less well equipped mentally than Europeans. I found variations in capacity such as one finds in Europeans, some being bright, some dull; but taken all over, the average intelligence did not seem inferior to the average of Europeans. In character they also varied. Some were unreliable, but many were trustworthy.

.... At Blantyre the young men learned to manage local dispensaries and dressing stations.... I may say here that if there is one lesson more than another that I have learned, it is that putting responsibility upon young people, and *trusting them* to carry it, is the way *par excellence* to develop character and capacity. A second lesson is that one must never set arbitrary limits to what human beings, of any race, can do.<sup>787</sup>

Before providing further examples and 'expert opinion', Macvicar presented his point as straightforwardly as possible: "Colour and intelligence are not related." He went on:

The outward differences between European and African peoples are so marked that it was natural to infer the existence of inward differences of brain and mind equally marked.... But – as far as science can today discover – a Negro, an Arab and a European have similar minds, and, given equal opportunities, are capable of similar achievements.<sup>788</sup>

With his typical predilection for basing conclusions upon science and various scholastic authorities,<sup>789</sup> Macvicar's conclusion for his intended white audience is clear: black Africans were not an inherently inferior ethnic group. Yet this

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<sup>787</sup> Neil Macvicar, *Western Civilization and the BANTU*, 25-26.

<sup>788</sup> *Ibid.*, 28-29.

<sup>789</sup> This method is exemplified in another work in which he personally wrote to and gained responses from thirty-five leaders in education throughout Africa, Neil Macvicar, *Africa Tomorrow?* (Johannesburg: South African Institute of Race Relations, 1947).

conclusion seems to contradict the course of action he took in the work which saw South African men trained not as doctors, but as medical assistants to white doctors.<sup>790</sup> And while maintaining the success of training medical assistants<sup>791</sup> at Blantyre, the drive to educate considerable numbers of men at the Victoria Hospital in South Africa largely failed.

#### *The Victoria Hospital Medical Assistant Education*

Shortly after Macvicar's arrival at Lovedale, young men had approached him wanting to begin training as medical assistants. Drawing upon the experience at Blantyre, and along with the competent leadership of Matron Mary Balmer, they began educating both a few women as nurses and men as medical assistants, following the gendered occupational norms which were widely held through the British Empire.<sup>792</sup>

By April of 1903, calls were issued for applicants of good character to apply. The course was designed to be three years in duration, with regular lectures on a plethora of health and medical subjects – such as Anatomy, Chemistry, Pathology, and Personal Hygiene – in addition to practical training areas such as nursing, drug dispensing, first aid, and medical dressing. In addition, for those deemed fit, an additional two years of study in medicine and surgery could supplement the

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<sup>790</sup> This was by no means unusual within Africa. Robert Laws, of the UFC Livingstonia mission in Malawi, explicitly wrote to the Acting Commissioner in 1906 that the goal of their training of African medical personnel was to assist European 'medical men'. Markku Hokkanen, *Quests for Health*, 327.

<sup>791</sup> The terms 'medical assistant', 'medical aid', 'hospital aide', 'orderly', and so forth, while occasionally technically unique, were largely used interchangeably by those within the field during this period. I typically use 'medical assistant' as a general reference to all of these, denoting both its specialisation and hierarchical position within the medical scheme.

<sup>792</sup> Marks, *Divided Sisterhood*; Gaitskell, 'Women Health and the Development of Medical Missions: Some South African Reflections', in *Gender, Poverty and Church Involvement*, 57-77.

preliminary hospital-issued certificate.<sup>793</sup> The African response, while not overwhelming, was suitable to the mission's capabilities for the period. Within a few years a small number of students who had completed the course found work in the health care field. Wetshootsile Michael Sechele, for instance, who had come from Molepolole, Botswana (then known as the Bechuana Protectorate), was one of these early pupils and upon leaving the Victoria Hospital was employed at the Mine Compounds Hospitals.<sup>794</sup> But for all of this, the fact remains that the object, however lofty as part of a long-term progression, was to educate merely a second-tier African medical establishment. In one of the early memos on the apprenticeship, the Victoria Hospital leadership made it clear that those who eventually qualified as a "Hospital attendant and Dispenser" had a very specific position in the wider medical scheme: "NOTE. This training is not intended to and will not qualify the apprentice as a Dispensing Chemist. It is intended to qualify him to act as a Dispenser in a Hospital under the supervision of the Doctor in charge."<sup>795</sup> Such a role relegated the African medical professional to a subordinate position, under a white physician.

In one of the most important writings on the subject of medical missionary attitudes toward medical higher education for Africans during this period, Macvicar proposed his scheme and reasoning behind the two-tier system in an article he submitted to the prestigious *Lancet* medical journal, early in his time at Lovedale.

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<sup>793</sup> *CE* April 1903, 52-53. This preliminary plan was greatly altered in the end, with the additional two years never materializing, and even the initial three year duration shortened to two years. See, Macvicar, 'Memorandum on the Training of Native Assistants', LC Cl, PR 3085, 7.

<sup>794</sup> 'Lovedale News', *CE* February 1913, 25.

<sup>795</sup> 'Conditions on Which Pupil-Apprentices will be Received into Victoria Hospital, Lovedale.', LC CL, MS 16,457, 1. This brief two-page, five-point summary was presumably put together by Macvicar and Hunter, and probably dates to circa 1903. The length of the apprenticeship herein is at three years, without any mention of a further two years.

The focus of his argument went beyond the most basic question posed at the beginning of his essay, “Will it be possible to give the natives at their present stage of development anything of the nature of a medical training?”, to which he answered: “I think one may say at the very outset that a complete medical course, such as is given in Europe, is at the present time quite out of the question for the natives of South Africa. There can hardly be two opinions about this, except, perhaps, among the natives themselves, who have no idea of the difficulty of a medical curriculum.”<sup>796</sup>

The editors of *The Lancet*, however, were some who actually had a different opinion on the matter. In the same issue in which his article appeared, they welcomed Macvicar’s proposal citing it as, “...affording not only a very ample and important outlet for native ambitions but also as likely to supply the colony with a large and eminently useful class of native practitioners, likely to exert a good influence among their own people and gradually to lead them along the path of sanitary progress.”<sup>797</sup> But they had fundamental problems with what they believed would be inadequately educated medical personnel and the long-term social implications of such a ‘second-rate’ system:

...We confess to have been somewhat puzzled by the limitations with which Dr MacVicar seems to think it desirable that the medical instruction of the natives should be surrounded. The proposal seems to be to supply, in the first instance, only half-educated men, and even to withhold the teaching necessary to inspire the licentiates, or whatever they are to be called, with the reasonable confidence in themselves and their attainments.... We are quite prepared to admit the possibility of imparting a modicum of medical knowledge to South African natives and of thereby doing a certain amount of good to the population, but we are none the less convinced that the formation of an inferior order of practitioners on any large scale or as in any

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<sup>796</sup> Neil Macvicar, ‘The Question of a Medical Training for Natives of South Africa’, *The Lancet* (23 September 1905): 909. This article was reprinted with the same title, in a condensed version, *CE* November 1905, 163.

<sup>797</sup> ‘Medical Education in South Africa’, *The Lancet* (23 September 1905): 902.

degree an arrangement intended to be permanent would be a mistake. .... and we would counsel all concerned, whether in South Africa or in England, to be more afraid of teaching too little than of teaching too much. The South African may or may not have limitations of capacity which must be considered in instructing him, but, so far as we are acquainted with the evidence, these limitations have not yet become apparent.<sup>798</sup>

Such critique was entirely valid, especially in its effort to shape the social acceptance of black male medical personnel as fully qualified and worthy of their status as biomedical practitioners.<sup>799</sup> Yet it may well have been removed from the realities within the South African context, both socially and educationally speaking.<sup>800</sup> And in fairness, Macvicar trusted that an inter-state college in the region could and would eventually provide a full medical course; before that came to pass, however, he felt a hospital-based course was achievable, would 'pave the way' for a fuller curriculum, and be of benefit to the wider society.<sup>801</sup>

As Macvicar's hospital-based educational format played itself out, the plan did not work as well as once hoped, though not wholly due to inefficiencies within the Victoria Hospital itself. As Lovedale was the first location within South Africa training both nurses and medical aids, the pressures of time and teaching proved too

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<sup>798</sup> Ibid., 902-903.

<sup>799</sup> Black African doctors had to train in Britain or America (an impossibility for the vast majority) but even upon their return faced problems in issues of treating white patients. See the insightful article, Anne Digby, 'Early Black Doctors in South Africa', *Journal of African History* 46 (2005): 427-454.

<sup>800</sup> Elizabeth van Heyningen has pointed out that while the medical professions in Britain were becoming more distinct – surgeon, doctor, pharmacist – in the late 19<sup>th</sup> century, this was not the case within South Africa at that time, as physicians tended to often do everything necessary. This is analogous to the later argument by Macvicar, in which he argued that South Africa had become more stratified and specialized in its health practitioners, whereas Malawi had need for medical practitioners, even of a 'junior' status, due to the lack of professionals. E.B. van Heyningen, 'Agents of Empire: The Medical Profession in the Cape Colony, 1880-1910', *Medical History* 33 (1989): 459.

<sup>801</sup> Macvicar, 'The Question of a Medical Training for Natives of South Africa', 909-910.

much for the limited medical staff<sup>802</sup> and in retrospect it is clear that the nursing program increasingly received the lion's share of attention within the hospital.<sup>803</sup>

There were other reasons for its slow demise as well. For one, prestigious and well paid job opportunities did not come to fruition, as was anticipated. Some district surgeons did not even want the assistance which Macvicar personally sought for some of the assistants he trained.<sup>804</sup> The first fully trained medical assistant from Lovedale received an income of £5/month at the Johannesburg mines. Within a very short time, these wages decreased to £3/month for further graduates – the same rate as other untrained medical assistants/orderlies working for the mine hospitals.<sup>805</sup> There is little cause for wonder as to why applications for the hospital-based medical assistant program would have fallen off when equal wages were paid to less-educated personnel.

In addition to the lack of heightened monetary compensation and the decreased demand, Macvicar himself lost interest in the scheme after particular episodes involving former students and what he felt were forays into medical matters beyond their expertise. One instance involved a graduate from Lesotho (then

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<sup>802</sup> Macvicar himself was the only lecturer and sometimes had to proceed at varying rates of instruction, depending upon the capabilities of the pupils. In an update to D.A. Hunter, who was then in Scotland, Macvicar remarked, "My classes are going on. I have just finished Physiology with Mosedi and Anatomy with the other three. Now they are at Materia Medica. The nurses are doing well." Repeating or staggering classes would have been very time consuming. Macvicar, Lovedale, to D.A. Hunter, Scotland, 17 September 1905, 'A', LC CL, PR 4150 (folder 2/4).

<sup>803</sup> While I cannot provide any evidence for this supposition, I do not find it unreasonable to believe that this may very well have been due to the influence of the hospital Matron, Miss Mary Balmer, who gave more attention and allowed a greater amount of practical training for 'her' nurses. While Macvicar and Balmer were both in charge of the nursing program, Macvicar alone would have been doing the vast majority of the medical assistant work. Furthermore, in these early years he was responsible for re-opening and running the hospital while heavily involved with the inter-State college planning, writing, miscellaneous Lovedale Mission obligations, and working on his doctoral thesis.

<sup>804</sup> Macvicar, 'Memorandum on the Training of Native Medical Assistants', LC CL, PR 3085, 5.

<sup>805</sup> Ibid., 6.

Basutoland) who eventually returned home after a short stint working in the mining medical services. After having been rejected by the Basutoland Administration's health services, he was given permission by the Paramount Chief to work as a medical doctor within that region. In one other case, another former graduate of the Victoria Hospital medical assistant scheme returned to his home region, obtained proper documentation to work as an herbalist, and set up practise as a doctor. When this medical assistant gave a white woman (what was most likely) a hypodermic morphine treatment, the Natal Medical Council investigated the matter and worked to make sure he did not take further employment above his medical 'station' or across racial lines.<sup>806</sup>

As B.K. Murray has rightly pointed out, mild displeasure amongst many white South Africans regarding the training of black African medical personnel grew to vehement disapproval on the further subject of whites being treated by blacks.<sup>807</sup> And Macvicar concurred with the Council's action: angry that the man had gone by the title 'Doctor'; disappointed that the Lovedale certificate (which the man did not even hold<sup>808</sup>) was being employed for something other than the intended use; and incensed that one of his former medical assistants was performing duties which he

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<sup>806</sup> Ibid., 5-6.

<sup>807</sup> B.K. Murray, 'Black Admissions to the University of the Witwatersrand, 1922-1939', *South African Historical Journal* 14 (November 1982): 38. This was not always the case, however, as with the case of Dr Molema, a black medical doctor some of whose white patients were quite happy with him as their physician – in direct opposition to some of the racist white nurses who resigned over the issue. See, Digby, 'Early Black Doctors in South Africa', 434.

<sup>808</sup> Macvicar did not issue the medical assistants their certificates for a full year after they had completed their educational training as he wanted to see how they conducted themselves; and this man had not received his. It was an obvious demonstration of his lack of trust with these students, even upon their completion of the course, and reveals very well the varying real and perceived levels of power and authority both with the medical professions as well as the wider society.



believed were only to be done by fully qualified medical doctors.<sup>809</sup> Such displeasure was voiced by others, such as Dr James McCord, of the American mission in Durban, when former medical attendant trainees went off the path prescribed for them (by those in authority).<sup>810</sup>

In fairness to Macvicar, he attached great significance to full and proper education prior to medical practice for the benefit of sick patients; this was the very reason he wanted to complement the medical system (district surgeons) with medical assistants, who, in Macvicar's opinion, could better interact and communicate with the patients.<sup>811</sup> Furthermore, he feared the grave, if unintended, repercussions from medical practitioners who did not understand the background of the medical procedures they were performing (as he believed was the case with most African traditional healers). Nevertheless, one cannot help but see the no-win predicament such Western trained African medical assistants were in while remaining in the Western system, as opposed to the greater amount of freedom, respect, and monetary advancement found in co-opting their training to a more contemporarily assimilated profession as traditional healers with Western biomedical training. Within a decade of its commencement, the Victoria Hospital medical assistant training program had largely withered to a standstill, though it struggled along well into the 1920s.

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<sup>809</sup> Note Macvicar's own words on this last matter, "... I did not train orderlies to give hypodermic injections or to dispense or handle dangerous drugs like morphia. This man had picked up whatever ideas he had about hypodermic injections in some illicit manner, probably from watching what others were doing in the ward." Macvicar, 'Memorandum on the Training of Native Medical Assistants', CL LC, PR 3085, 6-7.

<sup>810</sup> James McCord, *My Patients*, 120-121.

<sup>811</sup> Macvicar, 'Memorandum on the Training of Native Medical Assistants', CL LC, PR 3085, 5; SAO May 1923, 98; 'Medical Training for Natives', SAO May 1923, 104.

From even the earliest days of his involvement with the college, Macvicar's attention was attuned to plans for an enlarged and full medical course. In the earliest discussions which eventually led to the formation of the South African Native College at Fort Hare (SANC), Macvicar played an important role. While medical education was at the centre of his involvement, his participation within the matter was not relegated to this particular aspect of higher education.

### ***'Higher' Education and Medical Training***

#### *Macvicar and the Formation of the South African Native College*

A number of pieces have been written on subjects surrounding the formation of what eventually became known as Fort Hare University and medical education within South Africa during the first half of the 20<sup>th</sup> century. From the mission point of view, Alexander Kerr and Robert Shepherd, both at one point principals of the South African Native College and the Lovedale Institution, respectively, have provided 'insider' points of view of the process. With any typical shortcoming such perspectives often have, they have nevertheless provided unique information and insight for posterity.<sup>812</sup> In addition, there have been a number of publications in more recent decades, writing from assorted perspectives and highlighting a variety of important matters in the background of the history of higher education, and especially medical education, within South Africa.<sup>813</sup> Due to the work already done

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<sup>812</sup> Alexander Kerr, *Fort Hare*; Shepherd, *Lovedale South Africa, 1841-1941*; see also the Kerr Papers, Shepherd Papers, and Henderson Papers in the Lovedale Collection, Cory Library, Rhodes University. Kerr's book is notable, in this study, for its absence of detailed history leading to the formation of the College.

<sup>813</sup> Anne Digby, 'Medicine, Race and the General Good: The Career of Thomas N G Te Water', *Medical History* 51 (2007): 37-58; Jonathan D. Jansen, 'Curriculum as a Political Phenomenon', *Journal of Negro Education* 59, no. 2 (1990): 195-206; Karin A. Shapiro, 'Doctors or Medical Aids—

in portions of this subject area, the rest of this chapter details the central role Macvicar played in the establishment of the South African Native College (later Fort Hare) and both identifies and analyses what I believe were the principal factors in the unfulfilled program for higher medical education for black South Africans.

James Stewart, who had been the Principal of Lovedale during the latter decades of the 19<sup>th</sup> century, had long wanted an exclusive college for South Africans. Indeed, he strongly desired that the Free Church of Scotland, United Presbyterian Church, and Congregational churches work together to form a 'Central College' of higher education<sup>814</sup> – the scheme which Macvicar probably alluded to in a letter to Alexander Kerr saying, "Dr Stewart's previous attempt had been thwarted by ecclesiastical jealousy. He once said so much in my hearing."<sup>815</sup> – or for an outright transformation at Lovedale itself, eventually becoming a university.<sup>816</sup> Near the end of his life, a number of men became increasingly involved with the inter-State

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The Debate over the Training of Black Medical Personnel for the Rural Black Population in South Africa in the 1920s and 1930s', *JSAS* 13, no. 2 (January 1987): 234-255; Paul B. Rich, 'The Appeals of Tuskegee: James Henderson, Lovedale, and the Fortunes of South African Liberalism, 1906-1930', *The International Journal of African Historical Studies* 20, no. 2 (1987): 271-292; B.K. Murray, 'Black Admissions to the University of the Witwatersrand, 1922-1939', *South African Historical Journal*, no. 14 (November 1982): 35-53; Edward H. Berman, 'American Influence on African Education: The Role of the Phelps-Stokes Fund's Education Commissions', *Comparative Education Review* (June 1971): 132-145; D.E. Burchell, 'African Higher Education and the establishment of the South African Native College, Fort Hare', *SAHJ*, no. 8 (November 1976): 60-83. Of these, Burchell's essay on the formation of the SANC is tremendously thorough.

<sup>814</sup> *CE* February 1906, 20. This effort, pushed in 1882-83, was to be supported equally by all three churches.

<sup>815</sup> Neil Macvicar to Alexander Kerr, 27 July 1945, LC CL, PR 4150 (folder 3 of 4). Stewart continued his attempts at ecumenical involvement for the new College, even when he was constrained by ill health at the end of his life. See his two-page printed letter to the heads of other institutions, urging their involvement, dated 13 November 1905: James Stewart, LC CL, PR 4150, 'E'.

<sup>816</sup> Brock, *James Stewart and Lovedale*, 146. Lovedale previously had a 'College Department' which prepared students for the University of the Cape of Good Hope; Burchell, 'African Higher Education': 63-64.

college idea, most notably E.B. Sargant,<sup>817</sup> K.A. Hobart Houghton,<sup>818</sup> and Lord Alfred Milner, the High Commissioner. And by 1903 the South African Native Affairs Commission, chaired by Sir Godfrey Lagden, had begun looking at the issue with greater interest, eventually concluding, in 1905, that a ‘Native College’ ought to be established, “for the training of native teachers and in order to afford opportunities for higher education to Native students.”<sup>819</sup>

Just a week after Stewart’s death, in December 1905, a large ‘African Inter-State’ convention was held at Lovedale working toward the goal of establishment of the College.<sup>820</sup> The noted excitement for the scheme amongst many in the black African community was largely due to the heavy backing of the scheme by prominent members of the African elite community, such as John Tengo Jabavu,<sup>821</sup> Rev. John Knox Bokwe,<sup>822</sup> Rev. Simon P. Sihlali<sup>823</sup>, Chief Umhala, as well as whites

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<sup>817</sup> Sargant had been the Director of Education for the Orange River Colony and the Transvaal. Macvicar was adamant in his writings that Sargant receive the lion’s share of the credit for the early work in getting the idea materialized, including his work in both South Africa and Scotland.

<sup>818</sup> Houghton joined the Lovedale staff in 1903 as a teacher, and was Principal Teacher of the High School from 1910-1914. Thereafter, he became Inspector of Schools, from 1914-1940. Next to Sargant, Houghton was probably the most longstanding and dedicated member of the team pushing the inter-State college plan.

<sup>819</sup> Quoted in Brock, *James Stewart and Lovedale*, 146. For more on this process, and especially regarding the location of Fort Hare, see pages 146-159.

<sup>820</sup> For more on the African response and work, see Brock, *James Stewart and Lovedale*, 156-160.

<sup>821</sup> Jabavu, who was editor (from 1881-1884) of the black magazine, *Isigidimi sama Xhosa*, which was published at Lovedale, consequently started up and edited the much more independent newspaper, *Imvo ZabaNtsundu*, from 1884 – 1921, after coming into conflict with James Stewart. One of the most accomplished writers and respected voices in the educated black South African society (and beyond), in his last years he was also a professor at SANC. For more on his important role within the broader African intelligentsia during the late 19<sup>th</sup> century, see, Leon de Kock, *Civilising Barbarians*.

<sup>822</sup> Bokwe was educated at Lovedale and was an active black African intellectual in varying capacities, such as, co-editor at the *Imvo*, a Presbyterian minister, hymn writer, and author.

<sup>823</sup> Sihlali was the first black South African to pass the matriculation exams for the University of the Cape of Good Hope in 1880.

like J.W. Weir,<sup>824</sup> a successful King William's Town businessman – some of whom Macvicar had personally courted in the early days and worked behind the scenes to help.<sup>825</sup>

Yet it was Macvicar, still rather new to Lovedale, who was delegated by Stewart to personally approach influential personalities within South Africa. Amongst others, he approached Jabavu, “to try to secure his support for the scheme”, and Col. Walter Stanford, then the Chief Magistrate of the Transkei and Secretary for Native Affairs, as well as numerous other missionaries and educational leaders.<sup>826</sup> Part of this was due to the fact that other mission personnel within Lovedale were not in favour of the plan, and Macvicar had gained Stewart's intimate trust.<sup>827</sup> In the

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<sup>824</sup> Though Weir had withdrawn his support from Jabavu's *Imvo* during the Boer War, he was still reckoned by Stewart to be highly influential amongst the black South African community, and not simply through financial means. Macvicar, 'The South African Native College, Fort Hare, Historical Statement by Mr K.A. Hobart Houghton and Dr N. Macvicar', July 1945, LC CL, PR 4150, 'B', 2; De Kock, *Civilising Barbarians*, 138.

<sup>825</sup> Burchell, 'African Higher Education', 75.

<sup>826</sup> Macvicar, 'S.A. Native College Fort Hare Recollections', LC CL, PR 4150, 1-3.

Note that Sargent, on a trip to Lovedale, had specifically gone out of his way to seek support for the scheme from Rev. P.J. Mzimba, the leader of the newly independent Presbyterian Church of Africa (in Xhosa: *iBandla lama Presbitari ase-Afrika*), in addition to his further travels in Scotland and elsewhere within South Africa; Macvicar to Dr A. Kerr, July 1945, 'A', LC CL, PR 4150, 1.

<sup>827</sup> Space does not allow for the full disclosure of this aspect of the back story. Briefly stated, Rev. John Lennox, a teacher and theological instructor at Lovedale from 1892, and A.W. Roberts, Principal Teacher of the Training School who had been at Lovedale since 1883, and was Acting Principal in Stewart's absence (1899-1901, 1902-1904), were both opposed to the proposed transformation at Lovedale – Lennox highly doubtful that “the religious character” could be maintained in the proposed plan (then Sargent's), and Roberts in outright opposition. James Stewart was so incensed by their opposition to the plan, that he worked against their possible Principalship of Lovedale upon his retirement or death, convinced that they would scuttle the plans he'd helped put in place. Stewart wanted a successor that would carry forward his plan, proposing Dr Elmslie of the Livingstonia Mission in Malawi (then Nyasaland), or Kelman [?]. Roberts, as interim editor of *The Christian Express*, had disapproved of Macvicar's two lead articles promoting the College plan, but was overruled by Stewart, who demanded their printing. After attending a meeting with a number of prominent black Africans, of varying backgrounds, pledging their support for the plan, and apparently assuaging his fears about the religious nature of the new College, Lennox changed his mind by November. Macvicar, Lovedale, to D.A. Hunter, Scotland, 6 October 1905, 'B'; 30 October 1905, 'C'; 12 November 1905, 'D'; 17 November 1905, 'F'; 19 November 1905, 'G', LC CL, PR 4150. See also, Macvicar's very empathetic recollection regarding Lennox and Roberts and this issue: Macvicar to Dr [Alexander] Kerr, 4 December 1945, LC CL, PR 4150.

end, the decision which K.A. Hobart Houghton first proposed – that the Lovedale Institution not be used as the site for the new College – was adopted.<sup>828</sup> With the United Free Church of Scotland's donation of land the scheme was realised, with the SANC being built a couple of miles away from Lovedale.<sup>829</sup>

During this provisional period of setting up the SANC, Macvicar played an important role as a member of the Executive Committee,<sup>830</sup> both in setting the educational plans and schemes as well as in trying to garner widespread support amidst apathetic governments going through such changes as the establishment of the Union of South Africa in 1910, dissident perspectives in certain regions of the country, and the beginning of World War I.<sup>831</sup>

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In a very telling recollection, according to K.A. Hobart Houghton, M. Jacottet had travelled to Lovedale to discuss the College idea and upon leaving remarked to him, “‘I find all Lovedale is against this scheme except Dr Henderson, Dr Macvicar, + yourself’!” K.A.H.H. [Hobart Houghton], Innisfree, to [Alexander] Kerr, 28 November 1945, LC CL, PR 4150, 11.

<sup>828</sup> This was seen as a mistake by C.T. Loram who believed that, “the advantages of having Lovedale with its traditions, equipment, and many-sided activities as the nucleus of the new College” were completely missed. Charles T. Loram, *The Education of the South African Native* (London: Longmans, Green, and Co., 1917), 300 (note 1).

<sup>829</sup> Houghton changed his mind about the Lovedale Institution being the site for the College after a letter from Mr Dyke, then Principal of Monjo, as Dyke felt that the Institution would wither away under the shadow of the growing College – something he did not wish to see. Macvicar first opposed this change, but then came around to the idea, especially when the Fort Hare site, situated so closely to Lovedale, was put forward as a viable option, thereby allowing more of an unencumbered denominational identity. Macvicar to D.A. Hunter, 14 July 1944, LC CL, PR 4150 [1 page letter]; Macvicar to Dr A. Kerr, July 1945, LC CL, PR 4150 (folder 3/4), 7.

For more on the formation of the college, see, Burchell, ‘African Higher Education’, 60-83.

<sup>830</sup> In an official capacity, Macvicar was Secretary of the Inter State College Executive Committee from December 1909 – July 1911, though, as demonstrated, centrally involved from the very beginning.

<sup>831</sup> Travelling widely, his meetings included a veritable ‘who’s who’ of South African influential personalities, such as the then Basutoland Resident Commissioner, Sir Herbert Sloley; the Basutoland Council of Chiefs; South African High Commissioner, Lord Selborne; John Merriman, Prime Minister of Cape Colony (1908-1910); F.S. Malan, Cape Colony Minister of Education; the elder statesman, Jan F.H. Hofmeyr; former President of the Orange Free State, and then vice-president of the Closer Union Convention, Martinus Steyn; Abraham Fischer, the only Prime Minister of the Orange Free Colony (1907-1910); J.B.M. Hertzog, then Attorney General and Minister of Education in the Orange Free Colony; Sir John Fraser, chairman of the opposition Constitutional Party in the Orange Free Colony; General Jan Smuts, then Minister of Defence, for the Transvaal; and, H.C. Hull, Minister of



'Executive Board of Interstate College, 1907-1914

Back: Cr. Mamba, Cr Lehana, Mr Gasa, Mr Bud Mbelle, Mr J.T. Jabavu, Rev J Knox  
Bokwe, Rev Isaac Wauchope, Mr JP Mapikela

Middle: Mr N.O. Thompson, Sir Chas. Crewe, Sir Walter Stanford, Rt Hon JW Sauer, Rev J  
Henderson

Front: Mr KA Hobart Houghton, Dr N Macvicar.<sup>832</sup>

There were certainly difficulties during these dozen or so years, including limitations in the leadership, monetary shortcomings, governmental hesitations, and varied objections from portions of the white populace, such as industrial and professional workers who feared the loss of jobs due to the better educated blacks or some in education who maintained the 'Natives' of South Africa were then unfit for higher education as evidenced by their poor performance in passing matriculation

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Finance for the Transvaal. Neil Macvicar, 'S.A. Native College Fort Hare Recollection', LC CL, PR 4150 [1945], 6, 8-11.

<sup>832</sup> AMKWT 10276/HH2B. This quotation was from the back of the photo. Note that the gentleman in the back row, right hand side is not named in the photo.

examinations for the Cape University.<sup>833</sup> In the end, however, with enough funding provided and land given by the United Free Church, the scaled down South African Native College was ceremonially ‘opened’ by the South African Prime Minister, Louis Botha, on 8 February 1916, with a modest two-member faculty for the twenty first year students (two of whom were women).<sup>834</sup>

*Macvicar, the SANC and Medical Education*

While higher education for blacks<sup>835</sup> within southern Africa was central to Macvicar’s aim in the formation of South African Native College, the role of medical education was of especially great importance – and a goal shared by others in the South African missionary community. One of the respondents to Macvicar’s early letters requesting support for the proposal, Rev. William Girdwood of Tutura, wrote of the central importance of offering medical training at the new College.<sup>836</sup>

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<sup>833</sup> K.A. Hobart Houghton, ‘The Proposed South African Native College’, *Journal of the Royal African Society* 11, no. 41 (October 1911): 35-46; ‘The Educated Native’, *CE* May 1907, 69-71; ‘Natives and Higher Education’, *CE* May 1907, 72-73; ‘Native Education in Cape Colony’, *CE* March 1907, 34-35. This latter editorial, likely written by Houghton, was a response to an article in *The Education Gazette* (31 January 1907) maintaining that the inter-State college scheme was far too premature based upon South Africans’ educational abilities.

For objections and difficulties to the scheme, see Loram, *The Education of the South African Native*, 296-306.

Incidentally, some within the South African press cited and propagated the Lovedale Riot of 1920, in which approximately 200 of the Institute’s young men took part and damaged property and threw rocks at Dr Macvicar and Rev Lennox (who had tried to assuage the crowd), as evidence of the foolishness of educating blacks. Despite the Institute’s pleas for leniency, fifteen received the harshest sentences by the courts of three months of hard labour and fines of £50 (or a further six months of imprisonment). Shepherd, *Lovedale South Africa: The Story of a Century 1841-1941*, 336-339.

<sup>834</sup> ‘Edinburgh University and the Native College. A Parallel’, *CE* February 1916, 19; ‘The South African Native College’, ‘The Opening of the South African Native College’, ‘The Opening of the South African Native College Classes’, *CE* March 1916, 35-43; Kerr, *Fort Hare*, 3-58.

<sup>835</sup> The College’s intention was primarily for those of the ‘black’ and ‘coloured’ (then called ‘Native’) races, but was also open to students of Indian descent.

<sup>836</sup> Macvicar, ‘S.A. Native College Fort Hare Recollections’, LC CL, PR 4150, 3. Girdwood began his missionary work at the Tutura station, in South Africa, with the United Presbyterian Church in



According to an obituary in *The Christian Express* at the time of his death, Girdwood had previously written to the Colonial government in 1876, offering to supervise the medical education of four Africans in Britain, if the government would pay the students' expenses, but was declined. He wrote, at that time,

Nothing is more urgently required to aid in the civilization of these tribes than the having of a few Christian Natives thoroughly educated in medicine. It is a well-known fact that the majority, even of those commonly called school Natives and members of Christian Churches, teachers included, cling most superstitiously to their own philosophy of disease.<sup>837</sup>

A Swiss missionary in Lesotho (then Basutoland), Rev. E. Jacottet, according to Macvicar, "said he would not object to our starting a college at Lovedale if we would guarantee to make medical training part of the scheme. That, above all, was what they needed in Basutoland."<sup>838</sup>

In a sermon he delivered to the Lovedale congregation early in the process of trying to establish the College, Macvicar pointed out the aspirations he held for the school and fears he hoped would not come true. After expounding upon elements of what the SANC ought to instil in its pupils, in terms of character formation, he focussed on the central purpose he saw in the college's role:

Our students must learn to love truth for itself, not for the sake of the degree that comes with the knowledge; and they must learn to seek after truth for themselves and not be content with merely learning what other men have found out... The fields of natural science, *medicine*, history and many others lie open before them. Like students in other lands, they must do original work.<sup>839</sup>

As is clear from this quotation, Macvicar fully intended for medical studies to become a part of the SANC from its inception.

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1885; William J. Slowan, *The Story of Our Kaffrarian Mission* (Edinburgh: Offices of the United Presbyterian Church, 1894), 78-80, 116, 118.

<sup>837</sup> William Girdwood, quoted in, *CE* March 1907, 23.

<sup>838</sup> Macvicar, 'S.A. Native College Fort Hare Recollections', LC CL, PR 4150, 4-5.

Medical education, however, was not a central tenet of the College Committee's early scheme. This plan favoured, "(i) the training of higher-grade teachers (ii) a course of agriculture (iii) higher courses of general education."<sup>840</sup> And by the time the College finally began enrolling students – a decade later – amidst extremely humble beginnings, the absence of a medical course was probably due in part to the lacklustre experience with the Victoria Hospital-based education for medical assistants.

While mentioning the primary educative disciplines within the new college's scheme – ministry, teaching, law, business, and agriculture – the SANC Principal, Dr Alexander Kerr, glossed over the lack of medical education at the new institution. His opening address, while understandably positive, betrayed the hope once held by Macvicar and others:

Medicine is beyond us at present, even in the germ, but it is well to note that there are at least two fully qualified Native doctors practising in the Union, and that the first student enrolled in this college has stated that he intends to make medicine his profession. It is not the intention that every student should enter a profession, but there can be no doubt about the expediency of maintaining a supply of qualified professional men.<sup>841</sup>

By 1918, the SANC Board was again expressing a desire for supplying a full Medical degree, declaring, "These three professions, of Ministry, Teaching, and Medicine, it seems to us, make up the "red triangle" of Native progress, and training for them must engage the serious attention and the energies of the College in a very

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<sup>839</sup> Macvicar, 'Some Ideals in the Native College Movement', *CE* December 1906, 236 [emphasis mine].

<sup>840</sup> 'Progress and Aims of the Inter-State Native College Scheme' Letter to the Editor, *CE* March 1907, 47. This full page letter was written on behalf of the then Inter-State Native College Scheme Committee by James W. Weir (Chairman and Hon. Treasurer) and J. Tengo-Jabavu and K.A. Hobart Houghton (Hon. Secretaries), and appeared more like a full page ad, demonstrating Lovedale's commitment to the project.

<sup>841</sup> Alexander Kerr, in 'The Opening of the South African Native College Classes', *CE* March 1916, 42.

special manner.”<sup>842</sup> But the fact remained that amidst increasing elements of apartheid and restrictions on black freedoms during this period, Africans were not allowed admission to the universities with full medical courses, and consequently had to travel abroad for such studies (which was simply economically unfeasible for the vast majority).<sup>843</sup>

By 1921 no further advances with medical education within the College scheme had taken place. Yet three distinct developments, were converging to spark renewed interest and opinion on the discussion, debate, and work of training African medical men. The first of these was the Phelps-Stokes’ Report on Education in Africa and the visit to Lovedale and the SANC in 1921 by a few members of the Commission. Another important development centred on the involvement of the Rockefeller Foundation and its influence in prescribing the direction and content of medical education for Africans. Of final significance is Dr James McCord, medical missionary of the American Board in Durban, and the efforts toward a partnership between the SANC and Durban.

#### The Phelps-Stokes Commission on Education in Africa

From February to June of 1921 members of the Phelps-Stokes Commission on education in Africa toured South Africa, inspecting and evaluating various schools and educational facilities as part of their wider visit within Western, Southern, and Central Africa. The Phelps-Stokes Fund itself was an American philanthropic organization set up in 1911 through the will of Caroline Phelps Stokes,

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<sup>842</sup> ‘The South African Native College. Extracts from the Principal’s Report’, *CE* February 1918, 23.

<sup>843</sup> ‘Medical Education for Africans’, *SAO* November 1923, 247-248; Digby, ‘Early Black Doctors in South Africa’, 427-433, 448-454.

and it centred on aspects of educational needs, especially amongst the disadvantaged. In the period after the First World War and the establishment of the League of Nations, the Fund trustees voted to inaugurate a survey of education in Africa, with the cooperation of missionary societies, in the hope of, “adopting wise educational policies in Africa that would tend to prevent interracial friction, and to fit the Natives to meet the actual needs of life.”<sup>844</sup> The commission was headed by Dr Thomas Jesse Jones, the educational director of the Fund, who had studied sociology at Columbia University and previously worked at the Hampton Normal and Agricultural Institute<sup>845</sup> and the United States Bureau of Education. It also included Dr A.W. Wilkie, a UFCS Gold Coast missionary and later Principal of Lovedale in the 1930s, and Dr C.T. Loram, who had also studied at Columbia and was involved in the leadership of the SANC. In establishing the African Education Commission, the directors voted to seek out – and hence propagate – notions of adaptational learning in this important discussion: “...the type or types of education best adapted to meet the needs of the Natives...”<sup>846</sup> In so doing, however, they had bound together the African-American with the black African, and maintained that the systems which they favoured for black Americans – namely, industrial and agricultural education for a rural setting – were best for black Africans.<sup>847</sup>

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<sup>844</sup> Anson Phelps Stokes, ‘Introduction’, in Thomas Jones, *Education in Africa*, (New York: Phelps Stokes Fund, 1922), xiii.

<sup>845</sup> Now Hampton University, this historic black school was where Booker T. Washington studied and, along with Tuskegee, was one of the most notable institutions for “Negro education”.

<sup>846</sup> Quoted in Jones, *Education in Africa*, xiii.

<sup>847</sup> Kenneth J. King, ‘Africa and the Southern States of the U.S.A.: Notes on J.H. Oldham and American Negro Education for Africans’, *The Journal of African History* 10, no. 4 (1969): 659-677; Berman, ‘American Influence on African Education’: 132-145.

The Report is dotted with instances of dispelling common misperceptions held by those within the West, such as all of Africa being ‘the white man’s graveyard’, and full of hope on the advances of colonial health campaigns as well as the ability of an educated African elite. But at the same time it reinforced notions of African societies and ethnic groups as largely backward and less civilized than contemporary white Euro-America, and bolstered notions of trusteeship, a not uncommon sentiment during this period:<sup>848</sup>

The present distribution of the African groups through the various stages of human society, whether that stage be cannibalistic, barbaric, primitive, or civilized, is a natural condition that has been almost completely duplicated at some time with all civilized races... The improbability of the African is clearly shown by their response to the efforts of missions, governments, and commercial organizations.<sup>849</sup>

At its heart, with regard to the subject of this thesis, the Commission maintained that ‘adapted education’ was not, in its best forms, inferior to the traditional content of Euro-American education. Yet it belies the fact that if a particular country or society did not allow for socio-economic equality, which was increasingly the case in South Africa during this period, the point became moot. As others have maintained, the Commission’s work and suppositions were detrimental in their wholesale requisitioning of Africans to lower educational standards and content.<sup>850</sup>

Nevertheless, on issues of health education in schools, the Commission largely echoed for the rest of Africa what Macvicar had long maintained – that health, hygiene, and sanitation should be taught in South Africa, just as they were

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<sup>848</sup> Gossett, *Race*, 310-338.

<sup>849</sup> Jones, *Education in Africa*, 5-6.

<sup>850</sup> T. Jack Thompson, *Christianity in Northern Malawi: Donald Fraser’s Missionary Methods and Ngoni Culture* (Leiden: E.J. Brill, 1995), 239-248.

elsewhere in the world.<sup>851</sup> In their write-up on the subject, the Commission concluded that basic requirements were needed on the subject of health care education and curriculum. They went on to say,

5. Provision should be made for the special training of health workers, such as visiting nurses and medical assistants. This type of training is being developed by the government, cooperating with the missions of the Belgian Congo.

6. It is evident that the health and sanitation needs of Africa will increasingly require the help of Native Africans who have had complete medical and surgical training. Hitherto such training has been provided only by study in the medical schools of Europe or America. Colonial authorities and mission leaders are urging the development of two or three medical schools at centers to be selected for their accessibility and for their language possibilities.... It is to be hoped that the development of these schools may not be delayed until the full standards of European medical schools may be realized. Recent studies of medical needs among the primitive peoples justify the organization of medical schools of somewhat different standards, provided the policy requires the elevation of these standards as rapidly as financial and educational conditions make it possible. The graduates of such medical schools must of course receive the official recognition of the governments. This plan is now being definitely considered in the Union of South Africa, where efforts have been made to build a standard medical school in connection with Fort Hare, and a school of different standards in Durban.<sup>852</sup>

While the Commission spoke respectfully of Lovedale, they were not impressed with the educational curriculum, especially as it was not in accord with their adaptational pedagogy, particularly with hygiene, agriculture, and handicrafts (though this was tempered by blaming the influence of the Cape provincial education authorities).<sup>853</sup>

While praising Macvicar's work, their point was made in singling out the deficiency of healthcare instruction:

Similarly, physiology and hygiene are limited to a few lectures given by Dr. Neil Macvicar to the last class in teacher training.

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<sup>851</sup> [Macvicar], 'The Argument for Health-Teaching in Schools', *CE* August 1908, 117-118. Though not ascribed to Macvicar, I am very confident it was written by him. Neil Macvicar, 'Health Teaching in Schools – I', 'Health Teaching in Schools – II', 'Health Teaching in Schools – III', *CE* September, October, November 1908, 143-145, 165-166, 177-178. These articles were originally a paper Macvicar read at the South African Association for the Advancement of Science in Grahamstown in July 1908. Jones, *Education in Africa*, 18-20, 167, 197.

<sup>852</sup> Jones, *Education in Africa*, 19-20.

<sup>853</sup> *Ibid.*, 201-203.

In addition to his almost overwhelming responsibilities, Dr. Macvicar conducts a health class of 90 Lovedale students. It is a notable fact that this is the only class instruction in Lovedale Institution.<sup>854</sup>

In their recommendation for changes within South African higher education, the Commission specifically insisted on the advance of medical studies, writing, “[At the SANC] The increasing emphasis should be undoubtedly on such subjects as economics, sociology, physical sciences, and history; and also on such technical subjects as education, *medicine, and dentistry*.”<sup>855</sup>

While pushing their own brand of education, the Commission’s observations and recommendations were largely fair and to the point, both with regard to Lovedale as well as Fort Hare. The fact remained that after nearly two decades of planning and working toward academically institutionalized higher medical education for black Africans, the SANC leadership had failed to produce a working arrangement. The criticism over health education at Lovedale, however, is a bit more difficult. With the existence of the Victoria Hospital (with the presence of nurses and medical assistants being trained), the South African Health Society headquartered at the hospital, regular medical screenings of students, courses being given on health and hygiene, and Macvicar’s regular extracurricular lectures, group involvements, and preaching, it is hard to imagine a more implicit Westernised health care presence on the Lovedale campus, especially as compared with any other schools in a rural setting. Nevertheless, the Commission’s critiques of the contemporary setting and recommendation for more explicit medical and health

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<sup>854</sup> Jones, *Education in Africa*, 201, 203.

<sup>855</sup> Jones, *Education in Africa*, 222 [emphasis mine]. Note that they also recommended an extension of ‘health schools’ similar to some being carried out in Durban.

education undoubtedly aided the desires of Macvicar and others interested in establishing a medical course at the South African Native College.

James McCord and Durban

The Lovedale and South African Native College communities were not the only people actively pursuing notions of full medical courses for black South Africans in the early portion of the century. Dr James McCord of the American Board of Mission had been training nurses and medical assistants for a number of years at Durban in Kwazulu Natal. However, neither of McCord's programs had proved successful, owing in part to such things as inadequate nursing leadership on the part of the mission, unsatisfactory training of medical assistants, and McCord's not infrequent departures from the mission work.<sup>856</sup>

McCord had long propounded the need for educating native practitioners in a Western biomedical system, while deploring the medical treatment available to black Africans. As part of a regional missionary deputation, McCord and others approached the Natal Medical Council in late 1913 to encourage a medical assistant education and training system.<sup>857</sup> In his later recollection on the inactivity of the white medical community in caring for the health of the non-white communities during the early years of the 20<sup>th</sup> century he chided them, writing,

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<sup>856</sup> The former and latter reasons demonstrate a rather stark comparison with the Victoria Hospital which witnessed a very capable matron in Miss Mary Balmer and Macvicar's very rare furloughs back to Scotland.

Zondi, *Medical Missions and African Demand in Kwazulu-Natal, 1836-1918*, 199-237; McCord, *My Patients Were Zulus*, 93-96, 137- 157, 164-174.



The deplorable medical conditions among the Zulus were considered at a British Medical Association meeting [in South Africa] and a resolution was passed that “Health conditions among the natives of Natal and the lack of provisions to remedy them are a disgrace to a civilised community.” But the civilised community wore its disgrace lightly, nothing being done.<sup>858</sup>

He then urged the Durban Medical Society to support the training of medical aids who could then be sent into the rural districts (echoing Macvicar’s earlier scheme), but was met with near universal dissent among his colleagues.<sup>859</sup> After publishing a paper in the *South African Medical Record* calling for medical training for Africans, the journal responded with a number of editorials. While expressing appreciation for his thought on the subject, they disagreed with his 2<sup>nd</sup>-tier system for African medical personnel. However, the *SAMR* editorial board could not provide a complete and workable solution. They rejected both the notion of a “Native Medical Service” at government expense (which they maintained would lead to mediocre medicine and practitioners) and the idea of medical education for blacks within the concurrent South African system of higher education (segregation making this unfeasible even at a place like Cape Town University,<sup>860</sup> and cost prohibitive to start a new medical course at a place like Lovedale<sup>861</sup> for so few students). In the end, the medical journal concluded that the best option was to send Africans to Britain for medical training, while conceding: “Let us conclude, however, by saying that,

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<sup>857</sup> *South African Medical Record*, quoted in, ‘Deputation to the Natal Medical Council’, *CE* February 1914, 27-28.

<sup>858</sup> McCord, *My Patients Were Zulus*, 170.

<sup>859</sup> *Ibid.*, 170-171.

<sup>860</sup> Note that they did not, however, criticise this attitude. This double defence of white authority, the medical profession and medical educators, though sometimes varying in their approach or opinion, continued to cause deep problems for the advancement of education for black South African medical doctors – apart from the varying governmental denunciation or listlessness. See, for instance, Hofmeyr’s governmental contribution on this issue amidst these other groups, ‘Non-European Medical Students’, *SAO* May 1940, 81; or, Shapiro, ‘Doctors or Medical Aids’, 234-255.

anxious as we are to see some beginning, we confess that we are quite unable to definitely point the way. The difficulties, whichever way one looks, are stupendous.”<sup>862</sup> They were clearly resigned to maintaining a status quo in the medical education of black Africans, apparently unwilling to charter a new course of education in South Africa.

Though his venture was largely a solitary endeavour within Natal, McCord nevertheless went forward with a plan to establish a medical school. With the advent of American involvement in WWI, McCord travelled back to the United States to serve in the Army Medical Corps. His time in the U.S. (not even two weeks went by before the armistice was signed) proved doubly fruitful for his medical school plans. While in the Army he won the provisional promises of two medical doctors, Alan Taylor and J.W. Morledge, to join him back in South Africa. And upon his discharge, he was allowed by his mission to fundraise for the proposed medical school, acquiring £7,500 in pledges and cash. While this may have seemed a good start from his perspective, and without wanting to take anything away from his effort, the fact remains that this amount was a rather paltry sum, given the aims of his proposal.

By 1920 he returned to Durban, aiming to begin the new venture with help from any South African sources available. In a later write-up on the subject, McCord expressed his dismay at the initial reaction from the SANC at this time:

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<sup>861</sup> They refer specifically to Lovedale, but perhaps they were including the SANC in this phrasing. ‘A Native Medical Service: Is a Native Personnel Practicable?’, *SAMR* 16, no. 14 (27 July 1918): 210.

<sup>862</sup> ‘A Native Medical Service: Is a Native Personnel Practicable?’, *SAMR* 16, no. 14 (27 July 1918): 211. See also, ‘A Native Medical Service’, *SAMR* 16, no. 11 (8 June 1918): 161-164; ‘A Native Medical Service. Is a Native Personnel Desirable?’, *SAMR* 16, no. 13 (13 July 1918): 193-195.

This reaction [regarding him as “mildly insane”] in Durban was less disappointing than the hostile attitude of Dr. Alexander Kerr, the Scotch principal of the South African Native College at Fort Hare. When I wrote him, outlining my plans, he answered brusquely that he had no patience with a medical school which would turn out half-baked doctors to practise on a long-suffering public. If anything could have dampened my enthusiasm, it was this letter from a man known to be sympathetic to the natives, and one on whose moral support I had counted.

...Still, I believed that I could teach young natives how to care for their people in remote districts in a far better way than they were being cared for by their present medical men, the witch doctors.<sup>863</sup>

Undeterred, McCord found six young men whom he planned to groom to the best of his ability as “native doctors”, though not as South African government recognized doctors. He first sent them to the Adams Mission to study chemistry, zoology, biology, and physics for two years before returning to Durban for their further medical education. By 1923 five of these young men returned to McCord to continue their ‘medical schooling’. It was at this time that C.T. Loram, then a member of the SANC Council as well as a Durban native and old acquaintance of McCord, met with him. Upon learning of McCord’s plans, Loram advised him to discuss the ‘medical school’ proposal with Kerr once again because the SANC was slowly advancing its own designs. In what can only be seen as evidence of a tragic lack of communication, heavy denominational introspection, and/or pre-occupation with the internal affairs of his work, McCord was completely unaware of SANC’s medical education plans.<sup>864</sup>

In meeting with Principal Kerr at Fort Hare, McCord learned of the then dominant ideas amongst the SANC leadership: reliance upon the government for funding measures and not proceeding toward a lesser medical degree for the graduates of the course. While partially independent – in the early years of planning

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<sup>863</sup> McCord, *My Patients Were Zulus*, 175.

<sup>864</sup> Ibid., 178-179. Apparently Kerr must not have mentioned the SANC’s intentions in establishing the medical course in his response to McCord’s letter.

the South African Native College Executive Committee could boast that the black South African community had pledged £18,000 and £23,000 from 'European' (white) sources, before being withdrawn<sup>865</sup> – the SANC was depending on federal and provincial assistance for more buildings and faculty to enact the wider aim of an eventual full course. To this end, Henderson, the Lovedale Principal, and Dr Loram (chairman and vice-chairman of the SANC Council, respectively) had lobbied the South African Education Minister, Patrick Duncan, for government money to fund the medical course.<sup>866</sup> The SANC plan in early 1923 was to provide first year medicine, then send the students to Britain for their degree, with the hope of expanding to two years at Fort Hare before overseas completion and eventually for a full medical degree to be provided at SANC.<sup>867</sup> By the end of their meeting, Kerr was encouraging McCord to send 'his students' to Fort Hare, with the increasingly feasible possibility of combining the work of the College with Durban.<sup>868</sup>

By November of 1923 the SANC Council was given a report by Loram on the efficacy of a joint operation with the McCord and the American Board Mission in Durban. The Council adopted the committee's three recommendations: 1. accept the American Board's offer (pending the approval of the government and medical council); 2. finalise the details; and 3. begin the medical course at Fort Hare in

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<sup>865</sup> Weir, Houghton, and Tengo-Jabavu, 'Progress and Aims of the Inter-State Native College Scheme' Letter to the Editor, *CE* March 1907, 47. Most all of this funding fell through, however, as pledges went unfulfilled, governmental policies changed, and some promises were dependent upon matching funds which were not realised.

<sup>866</sup> 'Medical Training for Natives', *SAO* May 1923, 104-105.

<sup>867</sup> McCord, *My Patients Were Zulus*, 179-180.

<sup>868</sup> In one of the oddest aspects of McCord's later writing on this subject is that he is completely silent about this partnership between the SANC and Durban – probably because it failed. It is also quite possible that Dr Carter's ominous warning about the American Mission Board's utter lack of backing

February 1924. At that point, the Council envisioned that a full six year medical course would be divided with four years at the Fort Hare campus and the Victoria Hospital, with the remaining two years at Durban.<sup>869</sup> However, this arrangement never came to fruition. The plans were put on hold (and eventually dissolved) pending the possible involvement of the Rockefeller Foundation, a large American philanthropic organisation which had been involved in myriad educational schemes both in the United States and elsewhere in the world in the early 20<sup>th</sup> century, and to whose judgements the SANC eventually conformed their views.

#### The Rockefeller Foundation

By the end of the nineteenth century, John D. Rockefeller had become one of the most affluent men in the world. His early career in merchandising allowed him to invest in the Standard Oil Company which became the mainstay of his vast wealth for the decades thereafter. Along with other notable industrial figures of his day (pejoratively called ‘Robber Barons’ by many at that time), Rockefeller began giving away sizable amounts of his wealth to charitable causes and organisations. In 1891 Rockefeller tapped the former pastor and American Baptist Education Society executive secretary, Rev. Frederick T. Gates, to direct his philanthropic projects. In the ensuing years, Gates, along with both John D. Rockefeller Senior and Junior (father and son), targeted specific areas to concentrate monetary giving and through

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for McCord’s ‘medical school’ plan was in fact true. See, Macvicar to Kerr, 17 August 1924, LC CL, PR 4090, 3. For more on Carter, see the following section regarding the Rockefeller Foundation.

<sup>869</sup> W.T. Murdock, ‘South African Native College. Memorandum re Medical School’, [n.d. c. late 1924 or even 1925], LC CL, PR 4090, 1-2. Murdock was the Acting Secretary of the SANC Executive Council, and along with James Henderson and Neil Macvicar, was appointed to a committee to re-appraise the Medical School plans in light of recommendations provided by the Rockefeller Foundation.

foundations such as the General Education Board, Rockefeller money transformed arenas as extensive as the American medical system. From 1910 to 1930 alone, the Rockefeller Foundation (RF) gave away approximately \$300 million to pedagogical pursuits and research, a majority of which centred on medical education.<sup>870</sup> Yet this realm of influence was certainly not limited to the United States. As Christopher Lawrence has recently shown, the RF was also instrumental in altering aspects of medicine in older established centres, such as Edinburgh in the 1920s (though not as much as it once hoped).<sup>871</sup> In addition to involvement with established medicine in Britain, the Rockefeller Foundation worked to establish the Peking Medical Union College in China by 1921,<sup>872</sup> and by this time viewed South Africa as another undeveloped realm to help inaugurate what it viewed as progressively modern medical education.

In July and August of 1924 a Rockefeller Foundation representative travelled to South Africa as part of an investigative tour regarding medical education initiatives. Dr William S. Carter,<sup>873</sup> a medical doctor, had come on the RF staff as a member of the Division of Medical Sciences in 1922 before becoming associate director the following year. The SANC leadership had been in contact with the Foundation, having at one point provided written answers to their questionnaire

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<sup>870</sup> E. Richard Brown, *Rockefeller Medicine Men* (Berkeley: University of California Press, 1979), 13-50, 192-195.

<sup>871</sup> Christopher Lawrence, *Rockefeller Money, the Laboratory, and Medicine in Edinburgh 1919-1930* (Rochester: University of Rochester, 2005).

<sup>872</sup> Frank Ninkovich, 'The Rockefeller Foundation, China, and Cultural Change', *The Journal of American History* 70, no. 4 (March 1984): 799-803; John R. Stanley, 'Professionalising the Rural Medical Mission in Weixian, 1890-1925', in *Healing Bodies, Saving Souls*, 123-131.

<sup>873</sup> Carter had previously been professor of physiology and hygiene as well as dean at the University of Texas Medical Branch, in Galveston for over 20 years. Prior to his South African trip Carter had

regarding the proposed medical scheme and its contextual history.<sup>874</sup> After visiting Johannesburg and Durban, Carter stopped at Lovedale and Fort Hare to inspect both the College and Victoria Hospital as well as to enquire about the Council's plans for the medical course, which at that time were intimately tied to McCord's work at Durban. His visit did not prove encouraging toward their pre-existing plans. Through the unpublished private letters, notes, and memos of many of those involved, we can better understand the aims, intentions, and conclusions of those involved with the SANC, and most particularly Dr Neil Macvicar, in reaction to Carter's visit and their plans thereafter.

While many of the SANC leadership were impressed with Carter, both his background in medical educational systems and wide experience in the field,<sup>875</sup> his conclusion and judgements of their medical education scheme were quite disappointing; such that, to Macvicar's estimate, "Dr Carter's visit was somewhat of a cold douche", and in Henderson's words, "Yes, sir, he was most interesting and stimulating, but certainly not encouraging."<sup>876</sup> In essence, Carter was very critical of both the clinical facilities of the Victoria Hospital as inadequate (in the physical facilities themselves as well as the limited diversity of diseases students would encounter in their training and residency), maintaining that this training would have to be at a larger centre, and that classroom teaching ought not to be separated, to a

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spent time in the Philippines with the Foundation, and afterwards (1925) became the acting director of the Peking Union Medical College.

<sup>874</sup> Macvicar, 'Notes for Replies to Rockefeller Questionnaire' [filed with Macvicar to Kerr, 19 June 1923], LC CL, PR 4090, 1-2.

<sup>875</sup> D.A. Hunter to Alexander Kerr, 4 August 1924, 1; J. Lennox to Kerr, 20 August 1924, 1; C.T. Loram to Kerr, 25 August 1924, 1, LC CL, PR 4150. Kerr was in Scotland at this time.

<sup>876</sup> Macvicar to Kerr, 17 August 1924, 1; James Henderson to Kerr, 13 August 1924, 2, LC CL, PR 4150.

large degree, from the clinical education. While the SANC had planned on having the majority of the instruction at Fort Hare before the medical students were sent to Durban, by Carter's recommendation, only the first year would likely take place in the Eastern Cape, with the remaining four to five years occurring at Durban.<sup>877</sup> This greatly concerned the missionary leadership because they viewed the inculcation of 'character building'<sup>878</sup> and the camaraderie with other students of the college (the next generation African elite) as of utmost importance for the medical students. From the missionary standpoint, the students of the SANC were to be the *avant garde* of the next generation of black South African influential leaders. In this way, they viewed the course not solely from a standard of medical education efficiency (which was a part of their criticism of Carter); they believed that such a short time at the College would necessarily set the medical students apart to a degree as to make them largely autonomous and outside the vital realm of influencing and being influenced by the SANC community – students and faculty alike.<sup>879</sup> Though some may find fault with the missionary approach to this work as highly paternalistic, Lovedale had certainly provided a community which had witnessed the emergence of a number of the black intelligentsia of former generations from within its ranks.

Just as important as the response to the scheme's structure were what some of the SANC leadership felt was Carter's negative attitude toward the basic tenet of

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<sup>877</sup> W.T. Murdock, *South African Native College. Memorandum re Medical School*. [1924] LC CL, PR 4090 (folder 3/8), 1-2; Macvicar to Kerr, 17 August 1924, LC CL, PR 4150, 1-2.

<sup>878</sup> A. Victor Murray, *The School in the Bush*, 2<sup>nd</sup>, rev., ed. (London: Longmans, Green and Co., 1938), 117. Though speaking specifically of Lovedale, Murray captures the wider definition and importance of this term.

<sup>879</sup> Henderson to Kerr, 13 August 1924, 2; Lennox to Kerr, 20 August 1924, 2-3; LC CL, PR 4150; 'Statement to show the present position of plans for the medical training of Natives in South Africa', [1924], LC CL, PR 4090 (folder 3/8), 3.



training of black medical doctors in South Africa. In a letter to Kerr, Macvicar wrote:

In the first place he did not seem at all convinced that medical men – Natives – was what the country required. He insisted that until we had produced a large number of Native nurses, it was premature to think of a complete medical course. He seemed to think that a great deal of the sickness + the unhygienic conditions in the locations and country districts could best be dealt with by nurses who had a Public Health training in addition to their hospital training.<sup>880</sup>

And in all truth, for such sentiments to be directed at Macvicar from Carter is almost laughable, considering the pre-eminent position Macvicar had played in both the training for African nurses and helping open up the professional field for them, as well as his work in public health education and the establishment of the South African Health Society.<sup>881</sup>

And this feeling did not lie with Macvicar alone. In James Henderson's opinion, Carter had been too influenced by the 'anti-black education opinion' during his time in Johannesburg and Natal. "Considering how short a time he had been in the country he had imbibed an amazing supply of anti-college feeling. He took us back to all the stuff we had been up against in the days when the Fort Hare enterprise was still at the stage of discussion."<sup>882</sup> Henderson also essentially claimed that Carter's prejudicial stance against Filipinos, formed when he had worked in the Philippines for the Rockefeller Foundation previous to his South Africa trip, had been transferred to blacks, and hence affected his thought on the whole of education in South Africa:

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<sup>880</sup> Macvicar to Kerr, 17 August 1924, LC CL, PR 4090, 1.

<sup>881</sup> For a striking example of the far reaching effects of Macvicar's efforts, see, J.B., 'A Branch of the Native Health Society', *CE* July 1913, 108.

<sup>882</sup> Henderson to Kerr, 13 August 1924, LC CL, PR 4090, 2.

Where were the students for such a school? He [Carter] could not see them. The Filipinos – he was obsessed by them and interpreted our people always through his experience with that none too virile and persevering a race – sent many students in for medicine, but not twenty-five percent ever qualified, the leakage was so great. We pointed out that our experience did not bear this out with Bantu students. The men who went overseas were not of our selection either on the ground of character or ability, and could not be classed as really our best students, but they took the Edinburgh and Dublin degrees. Mitchell, I think, had influenced him in Johannesburg, and other cold water distributors there and in Durban.<sup>883</sup>

In addition, Macvicar seemed to find Carter unadaptable and uncompromising to the conditions of missionary led work in Africa – monetarily, physically, educationally, etc. If Macvicar did not have a problem with a small town or rural setting as a centre for medical education – citing St Andrews, Oxford, and Cambridge as notable examples – Carter’s reply (according to Macvicar) was, “that no one starting to now should start on such lines.”<sup>884</sup> His further attempts to explain expansion plans for the hospital, and hence a wider availability of both ill health cases and laboratory space, also failed to gain a receptive audience with Carter. While he appreciated Carter’s examination of their plan, from an externally critical perspective, a deep scepticism seemed to reside within Macvicar on how much leverage the Rockefeller Foundation ought to have in the South African Native College medical education scheme.<sup>885</sup>

In the end, the SANC Executive Committee took up Carter’s recommendations and attempted to adapt plans, appointing Macvicar, Henderson, and the Acting Secretary, W.T. Murdock, to gather further opinions and advice on the matter within the Union.<sup>886</sup> It was a further delay that ultimately proved of little

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<sup>883</sup> Henderson to Kerr, 13 August 1924, LC CL, PR 4150, 2.

<sup>884</sup> Macvicar to Kerr, 17 August 1924, LC CL, PR 4090, 2.

<sup>885</sup> Macvicar to Kerr, 17 August 1924, LC CL, PR 4090, 4.

<sup>886</sup> W.T. Murdock, ‘South African Native College. Memorandum re Medical School.’, LC CL, PR 4090 (folder 3/8), 2.

help for the implementation of a medical education scheme both at the College and within South Africa.

#### The SANC and Medical Education in the late 1920s and 1930s

By as late as 1944 Dr Roseberry T. Bokwe, son of John Knox and Maria Bokwe, could write that he was but one of “ten registered African medical practitioners in South Africa as against some 3,000 European medical men.”<sup>887</sup> Bokwe and others, such as C.N. Dhlamini, S. Molema, and I. Monare,<sup>888</sup> had been forced to travel to Britain and elsewhere to conduct their studies to become medical doctors, a system supported through scholarships by such organisations as the Transkeian Territories’ General Council.<sup>889</sup> Despite the efforts of particular individuals and groups, blacks could not obtain full medical degrees within South Africa until the advent of World War II. With scholarships available from the Smuts government, which wanted medically trained blacks for the war effort, the University of Witwatersrand finally agreed to admit a very limited number of students in 1939,<sup>890</sup> though the first students did not enter until 1941, by which time the University of Cape Town also began admitting non-whites.<sup>891</sup> Not by chance, five candidates for 1941 were alumni of Fort Hare: Howard Hermanus, James Jnongwe, Donald Moikangoa, William F. Nkomo, and Albert Mzoneli.<sup>892</sup>

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<sup>887</sup> R.T. Bokwe, ‘An African Medical Practitioner’, *SAMJ* 18, no. 24 (23 December 1944): 415.

<sup>888</sup> These three had qualified by 1939, at which time there were nine other black South Africans studying for medical degrees outwith South Africa. ‘Bantu Medical Graduates’, *SAO* August 1939, 173.

<sup>889</sup> ‘Medical and Dental Training of Non-Europeans’, *SAO* March 1941, 45.

<sup>890</sup> Murray, ‘Black Admissions to the University of the Witwatersrand, 1922-1939’: 36.

<sup>891</sup> Digby, ‘Early Black Doctors in South Africa’, 434; Schapiro, ‘Doctors or Medical Aids’, 254.

<sup>892</sup> ‘Medical and Dental Training of Non-Europeans’, *SAO* March 1941, 45.

After forming a committee to explore the recommendations of Dr Carter and the Rockefeller Foundation, the SANC leadership largely dismissed the possibility of moving forward on their planned full medical course. With the South African government's increased attention to 'Native Affairs',<sup>893</sup> primarily through the appointment of the 'Loram Committee',<sup>894</sup> to investigate the matter of training black South Africans, the SANC largely passed responsibility on to others from the late 1920s to the early 30s. Having accepted Carter's critiques that the cost was too great for such a small number of students they felt the onus of groundwork was best met by the Union government.

Macvicar continued his pleas for action through editorials in the missionary press, some in defiance of Carter's recommendations.<sup>895</sup> He maintained that though there were obstacles, primarily financial, the need was present and the government was the only one able to provide proper funding. While continuing to propound the efficacy of black African doctors, in that they alone could understand and communicate properly with the black African patients, let alone the need for a Western biomedical presence among the masses, Macvicar resigned himself to the realities of the increasingly segregationist sentiment and system. In a very revealing editorial, Macvicar seems to have given up on the dreams he once held for a full medical course, looking to what might be viewed as a more pragmatic approach:

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<sup>893</sup> J.F. Herbst, 'The Administration of Native Affairs in South Africa', *Journal of the Royal African Society* 29, no. 17 (October 1930): 484-485.

<sup>894</sup> Led by C.T. Loram, then of the Native Affairs Commission, with leaders from medical and education spheres in the four provinces also serving.

<sup>895</sup> [Macvicar], 'Medical Education of Natives', *SAO* April 1926, 80-81. This particular piece centred on the view that the whole medical scheme ought to be based within a College, not independent of it. This editorial is ascribed to Macvicar in Shepherd, *A South African Medical Pioneer*, 235, as with the following note.

It will naturally be asked “What is to become of a student who takes the first or second years in this country, if the school cannot be built up year by year to cope with his progress through the course?” Is he to be turned out with anatomy and physiology, but no pathology, medicine or surgery? He would indeed be unfortunate. Is he to continue at Capetown [sic] or Johannesburg? Racial feeling would forbid it. Is he to complete his course in Britain? Unaided, he cannot undertake the expense. The solution that commends itself to us is that, having gone as far as he can at his Native College, it should be made possible for him to receive help in the form of a bursary or a loan... so that he may continue his studies at an English or Scottish University and return to his own country to practise.<sup>896</sup>

During this period of the late 1920s, Macvicar continued to work within the confines of the SANC to establish a medical course, while concentrating on the other realms of public and health education, including his teaching at Lovedale, the South African Health Society, and Nursing training at the Victoria Hospital. The College was continuing to educate students in a first year course of medicine, so that they could go on to obtain their medical degrees at Universities overseas, and by 1927 nine students had attained these degrees (two from the University of Edinburgh).<sup>897</sup> Yet proactive initiatives to firmly establish a full Medical Course to train doctors never came to fruition. In 1937, Macvicar’s last year of active service as a medical missionary, Fort Hare began training medical aides, but the scheme was abandoned just a few years later in 1943.<sup>898</sup>

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<sup>896</sup> [Macvicar], ‘Native Medical Training’, *SAO* March 1926, 56.

<sup>897</sup> H.L. Henchman, *The Town of Alice with Lovedale and Fort Hare* (Lovedale: Lovedale Institution Press, [1927]), 35.

<sup>898</sup> Digby has maintained that it was due to poor recruiting; perhaps this is due in part to the advent of medical schools then available after 1941. Digby, ‘Early Black Doctors in South Africa’, 434.

## ***Concluding Remarks***

Most mission attitudes regarding African higher education in the early 20<sup>th</sup> century continued to be under the impression that they knew what was best. In a rather telling excerpt in a personal report from the International Missionary Conference on ‘Missions in Africa’ held at Le Zoute, Belgium, in 1926, one member wrote,

If every missionary who attended the Conference calls his Native flock together on his return to Africa and tells them fully and frankly of the discussions at Le Zoute and of the recommendations adopted, thus only can the Conference reach the vast continent in the solution of whose problems they were endeavouring to assist.<sup>899</sup>

Such sentiment accurately describes the way in which most Western interests spoke to Africans about matters of education; not with them, but to them. And under the influence of recommendations as given by the Phelps-Stokes Commissions, leading mission opinion tended toward adaptational learning, even for higher education, within much of Africa,<sup>900</sup> thereby limiting the potential ability for standards equal with North Atlantic students.

Unlike any other area of his missionary labour, Macvicar’s drive for higher education for black African students was almost continuously mixed with mild successes and outright failures. While so full of optimism for the imminent establishment of higher education and a full medical training for African men while at Blantyre at the end of the 19<sup>th</sup> century, Macvicar’s dreams were never realised in the manner in which he planned, either in Malawi or in South Africa. Working as a member of the core group working to establish the then-termed Inter-State Native

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<sup>899</sup> A Consultative Member of the Conference, ‘Impressions of Le Zoute’, *IRM* 16 (1927): 38.

<sup>900</sup> J.H. Oldham, ‘The Christian Mission in Africa As Seen at the International Conference at Le Zoute’, *IRM* 16 (1927): 31-32.

College in the first years of the new century, Macvicar demonstrates a diligent devotion to higher education for black South Africans. As this thesis has demonstrated, education – the furthering of understandings and the transference of knowledge – was of vital importance to this medical missionary. For Macvicar, a Christian sponsored college of higher education brought together what were in his mind the very best elements of moral standards and scholastic discovery. Naïvely idealistic as it may sound to some, his approach to missionary work rested in the belief that academic availability and advances, especially in the sciences, by people of all races were for the benefit of all humanity.<sup>901</sup>

Though non-white South Africans finally gained entrance for medical degrees at the Universities of Cape Town and Witwatersrand by the time of the Second World War, this was a decidedly different arrangement than Macvicar had envisioned. While he resigned himself early in his South African experience to a belief that a medical school for African doctors could not be readily established, he continued to work toward the goal for decades. Frustrated in his personal plans for establishing a medical course by a host of adversarial conditions – governments, endemic racism, financial difficulties, disagreements with the Rockefeller Foundation – this portion of his missionary labour mirrors the earlier difficulties which Lovedale had in trying to establish a medical presence at the mission in the 19<sup>th</sup> century. All through this, however, Macvicar is a notable figure as he continued to work for both higher education and advanced medical degrees for black Africans, amidst an increasingly hostile South African environment.

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<sup>901</sup> Macvicar, 'Science, Bond or Free?', *SOA* March 1943, 46.

## Conclusion

The inclusion of medicine into the wider mission of Lovedale was slow in coming. It is, in some ways, rather perplexing that this Scottish mission was established in the same year, 1841, as the Edinburgh Medical Mission Society began, all while having no interaction. Amidst a century in which there was growing motivation and justification for bringing medical service within the wider North Atlantic missionary movement, as demonstrated in chapter one, Lovedale did not embrace medical efforts as a part of its core values.

When medical work was undertaken at the mission in the last few decades of the nineteenth century, we have seen that it was carried out as an auxiliary aspect of the mission. And what is more, the main perpetrators of any focussed and determined medical mission work at Lovedale during this time were ‘outside’ players, especially recognisable for what they were not: white male doctors. In Jane Waterston, a female physician who was treated with a great deal of disrespect by the mission leadership at Livingstonia as well as the Foreign Mission authorities in Scotland, and Govan Koboka, an African dispenser, we have people who were largely marginalised within the realm of either medicine or mission. Additionally, it was to take the determined work of a non-medical honorary missionary to Lovedale, D.A. Hunter, to bring to fruition the plans for a hospital at Lovedale. It was Hunter and Macvicar’s close cooperation during the subsequent decades which allowed the Victoria Hospital to move forward from its troubled first years.





"Dr Neil Macvicar and Mr D.A. Hunter in front of Old Victoria Hospital about 1920"<sup>902</sup>

This picture was almost certainly taken on a holiday or other special celebration. Note the nurse standing behind Macvicar and the hospital patient beds on the porch; patients were often brought outside for fresh air and exposure to sunshine, especially if suffering from tuberculosis.

In the person and work of Dr Neil Macvicar we have an outstanding subject for the historical study of medical missions. For scholarly examination both he and the other medical personnel of the Victoria Hospital, Lovedale, offer not simply an example of how such work was carried out, but a unique case study for a variety of reasons. As one of the first in the South African context, the Victoria Hospital was engaging in its work years before the more wide-scale build up of mission hospitals

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<sup>902</sup> AMKWT 1669/SH 032/H/B. It is more likely this picture dates from the middle or latter portion of the decade.

in the 1910s and 20s. And indeed, there is need for more scholarly work on this institution and the nuanced and fascinating figure of Macvicar, which this thesis does not allow space for, particularly in the realms of medical ethics, notions of civilisation and race, South African public policy, and ecumenical missionary involvement. While further study must be done, this thesis has provided the most thorough analysis of the medical missionary work carried out by Lovedale, Dr Neil Macvicar, and the Victoria Hospital during the late 19<sup>th</sup> and early 20<sup>th</sup> centuries.

One of the notable themes I have demonstrated through this thesis is the very wide-ranging approach in his medical mission work. If other medical missionaries had emphases in their work, Macvicar displays a remarkably varied array of interests for his mission task. Agnes Fraser, a Scottish Presbyterian missionary physician in Africa at the same time as Macvicar, for instance, provides an adequate juxtaposition. While she was certainly involved with routine medical care, and burdened to a certain degree with limited responsibilities due to her official status as the ‘wife of a missionary’,<sup>903</sup> her mission strategy emphasised work amongst women, especially as she believed that they were the key to shaping Africa’s future.<sup>904</sup> If Fraser’s prominent pursuit could be construed as an approach like a rifle, Macvicar demonstrates an approach that might be seen more like a shotgun, with the plethora of areas in which he was actively involved.

As I have shown, during his decades at the Victoria Hospital, Macvicar was ‘hands on’ as a physician providing routine clinical primary medical care and

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<sup>903</sup> Female missionaries typically did not hold the status, and compensation, of an ‘official missionary’ if married, though many worked in capacities which were, for all intents and purposes, as though full time missionaries.

<sup>904</sup> Fraser, *The Teaching of Healthcraft to African Women*, passim.

performing surgical procedures regularly for local patients as well as members of the Lovedale mission. He was also involved in teaching health classes and other health science courses, both for students of Lovedale as well as the South African Native College/Fort Hare. His involvement with the student population did not end there as he spoke to student groups, such as 'The Brotherhood of Honour' or 'Total Abstinence' sub-committee of the Students' Christian Association,<sup>905</sup> preached at chapel meetings, and assisted in student events, such as the 1917 Students' Christian Association Conference. As I demonstrated in chapter six, Macvicar was steadfastly dedicated to the promotion and establishment of higher education for black South Africans within South Africa, which eventually resulted in what is today known as Fort Hare University. As has repeatedly been mentioned he was one of the earliest missionaries to be involved with the training of African nurses and medical assistants, while also trying to establish a full medical course (though unsuccessful). As a writer and contributor to professional gatherings, Macvicar was rather prodigious. His articles on medical issues were published in such journals as *The Lancet* and the *South African Medical Record* as well as missionary-minded work in the *International Review of Missions*. He was the author of an untold number of short write-ups on health matters in the *South African Health Society Magazine* in addition to his years of supplying articles on a host of topics in *The Christian Express* and *South African Outlook*.

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<sup>905</sup> Lovedale Students' Christian Association, 1911, 3; Lovedale Students' Christian Association, 1913, 1, 2, 3; Lovedale Students' Christian Association, 1914, 1; Lovedale Students' Christian Association, 1915, 1, 2, 3. AMKWT, Lovedale Box.



“Students' Christian Association Conference, 1917, Lovedale.”<sup>906</sup>

Though this photograph has deteriorated, Macvicar can be seen seated on the bench, the furthest to the left, with the elderly John Knox Bokwe seated next to him.

And his role as a mentor to black medical workers within South Africa, his work in training visiting missionaries in tropical medicine and basic health care, as well as the management of the Victoria Hospital staff and participation on the Hospital Board, all cannot be overlooked. Of final mention is his wider work in authoring books and pamphlets for popular consumption not only on a variety of health care related topics, such as nutrition, disease, public health, and hygiene, but on issues of race relations as well.

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<sup>906</sup> Photograph 1212, CL LC. Unfortunately, no names were recorded on this photo.

Though involved in all of these arenas, an important aspect of Macvicar's approach to medical mission work is seen in recognising why he was so widely engaged. Anne Digby, the historian of colonial medicine in South Africa, has remarked that "District surgeons perceived themselves to be a front line not just in the fight against disease, but thereby also in the advance of imperial civilisation."<sup>907</sup> In a similar, though notably different way, Neil Macvicar thought of himself as on the front line of advancing 'Christian civilisation'.

Accordingly, he worked in a variety of capacities to try to bring better health care, scientific comprehension of disease causation and dissemination, access to higher education, and medical training to the South African black population. All of these efforts were part of the 'civilising' work of mission and what he believed of utmost importance. Echoing the earlier words of Henry Drummond,<sup>908</sup> he held that the primary reason for his work rested in trying to help 'uplift' the state of Africans. This motive rested in his optimistic belief that the betterment of humanity was a goal which could, at least in part, be realised.<sup>909</sup> For Macvicar, this was based in his perception of the 'Christianising' effort.

Nearly a century before his time a sometimes bitter debate had raged over the question of what should come first in missionary methodology: the proclamation of the Gospel or efforts to 'civilise'.<sup>910</sup> In Macvicar's mind these were not at all mutually exclusive – in fact, they were intimately tied together. As I demonstrated in

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<sup>907</sup> Anne Digby, 'Making a Medical Living', in *The Cape Doctor*, 268.

<sup>908</sup> Henry Drummond, *The Lowell Lectures on The Ascent of Man* (London: Hodder and Stoughton, 1897), 49-50.

<sup>909</sup> Macvicar, *Western Civilization and the Bantu*, 32-33.

chapter three, his theological views were certainly not in line with broader evangelical teachings, so widespread in missionary circles during this period. His proclamation of Christian conversion was therefore not focussed upon a 'point of conversion', the common directive of asking Jesus to become one's personal Saviour or indwelling of the Holy Spirit. Rather, it centred on the incorporation of traditional Christian ethical standards and particular manners of life, such as family structure or alcohol temperance.<sup>911</sup> He propagated a conversion in heart and mind in line with European Christian standards.

At the same time, his ardent desire was for the extinction of many African traditional methods of healing and understandings of ill health, manners of living, and belief in the active existence of supernatural powers or entities and other 'superstitious' ideas. Throughout his career, Macvicar was convinced that these beliefs were injurious to both individuals as well as African societies.<sup>912</sup> With this said, he did not object wholesale to southern African cultural customs. While referring to black South African societies as "backward", on the one hand, he also expressed marked admiration for characteristics and traits which he implicitly implies were markedly absent within white South African society:

Civilisation, however, as we have seen, is not all outward, mechanical, visible. There is a civilisation of the heart as well... [and what has] developed in them [are] certain qualities that are not too common elsewhere – such qualities as patience, courtesy, unselfishness and mutual helpfulness.<sup>913</sup>

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<sup>910</sup> Ian Douglas Maxwell, 'Civilization or Christianity? The Scottish Debate on Mission Methods, 1750-1835', in Stanley, ed., *Christian Missions and the Enlightenment*, 124.

<sup>911</sup> Ibid., 33; 'The Christian Man's Attitude Towards Women and Girls', *CE* May 1914, 73-74.

<sup>912</sup> Macvicar, 'The Need of Health Teaching in Evangelism', *SAO* June 1936, 135-137.

<sup>913</sup> Macvicar, *Western Civilization and the Bantu*, 21-22.

Such sentiment demonstrates a commitment to the values he held, viewing them as Christian, no matter their social origin.

At the heart of the matter, Macvicar undoubtedly found the enduring pre-colonial African societal norms and worldviews to be incorrect, unchristian and uncivilised.<sup>914</sup> Convinced that he had an obligation and privilege to correct these notions and with faith that his scientifically informed understandings of the world would be heard and trusted by people of common humanity,<sup>915</sup> he worked to remedy what he perceived to be injurious. To this end, he engaged in a wide array of missionary work, believing that it all would lead to a better condition of life for all involved.

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<sup>914</sup> Macvicar, *Africa To-morrow*, 89-98.

<sup>915</sup> Ross, 'Christian Missions and the Mid-Nineteenth-Century Change in Attitudes to Race: The African Experience', in Porter, *The Imperial Horizons*, 86, 90.

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<sup>916</sup> Note that in *LWBCA* authorship of articles ceased after the first month, probably due to a change in editorship. There is little doubt that Macvicar continued to write many of the articles appearing in the journal, but ascribing authorship would lack certainty.



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<sup>917</sup> This is not a verbatim text, but covers Macvicar’s tribute.

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<sup>918</sup> See also, in response to a portion of this review, H.A. Stick ‘Letter to the Editor – Tobacco.’ *SAO*, June 1935, 132.

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